STATE TITLE V BLOCK GRANT NARRATIVE
STATE: NJ
APPLICATION YEAR: 2005

I. GENERAL REQUIREMENTS

A. LETTER OF TRANSMITTAL

The Letter of Transmittal is to be provided as an attachment to this section.

B. FACE SHEET

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. ASSURANCES AND CERTIFICATIONS

Assurances and certifications are available and maintained on file in the Office of the Assistant Commissioner of the Division of Family Health Services.

D. TABLE OF CONTENTS

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

E. PUBLIC INPUT

To include public input into the annual development of the MCH Block Grant Application and Annual Report, a public hearing is held and a draft of the report is posted on the Department's website. The public hearing was held on May 18, 2004, in Trenton to review the draft of the Maternal and Child Health Block Grant Application. Testimony was received from twelve individuals. A draft of the application was posted on the Department's website (www.state.nj.us/health/) four weeks prior to the public hearing. Notice of the public hearing was published in local newspapers throughout the State. Notification of the public hearing and availability of the draft application on the Department's website was mailed to over three hundred individuals on the Division of Family Health Services mailing list. Public comments addressed the need for continuing support for the comprehensive Child Evaluation Centers, the Maternal Child Health Consortia and the children with special health care needs (CSHCN) case management system. Providers of services to CSHCN cited barriers to providing comprehensive care such as low reimbursement rates from managed care providers, difficulty locating dental providers and increasing case loads for case managers. Several commentors provided examples of the diverse MCH programs supported by Title V funding and the Division of Family Health Services. Input into Title V activities are encouraged throughout the year through involvement of individuals and families in the many advisory groups and task forces as described in Section III.E.

II. NEEDS ASSESSMENT

In application year 2005, the Needs Assessment may be provided as an attachment to this section.

III. STATE OVERVIEW

A. OVERVIEW

The Maternal and Child Health block grant application and annual report, submitted annually by all states to the Maternal Child Health Bureau (MCHB), contains a wealth of information concerning State initiatives, State-supported programs, and other State-based responses designed to address their maternal and child health (MCH) needs. The Division of Family Health Services (FHS) in the New Jersey Department of Health and Senior Services (NJDHSS) posts a draft of the MCH Block Grant application and annual report narrative to its website to receive feedback from the maternal and child health community.

A brief overview of New Jersey is included to provide a background for the maternal and child health needs of the State. While New Jersey is the most urbanized and densely populated state with 8.4 million residents, it has no single very large city. Only four municipalities have more than 100,000 residents. The State's population is projected to grow steadily, but slowly, through the year 2010 to just over 8.5 million.

Compared to the nation as a whole, New Jersey is more racially and ethnically diverse. According to the 2002 New Jersey Population Estimates, 77.6% of the population was white, 14.5% was black, 6.3% was Asian or Pacific Islander and 1.1% reported two or more races. In terms of ethnicity, 14.2% of the population was Hispanic. The racial and ethnic mix for New Jersey mothers, infants, and children is more diverse than the overall population composition. In 2002, 21.7% of mothers delivering infants in New Jersey were Hispanic, 72.4% were white, 17.5% were black, and 8% were Asian or Pacific Islanders. The growing diversity of New Jersey's maternal and child population raises the importance of addressing disparities in health outcomes and improving services to individuals with diverse backgrounds.

Maternal and child health priorities continue to be a focus for the NJDHSS. Specific attention has been placed on the reduction of racial and ethnic disparities in health outcomes, especially black infant mortality, preterm births, childhood lead poisoning, obesity prevention and reduction of risk taking behaviors among adolescents.

The Division of FHS, the Title V agency in New Jersey, has identified improving access to health services, reducing disparities in health outcomes and increasing cultural competency of services as three priority goals for the MCH population.

Since 1992, the State has provided reimbursement for uninsured primary medical and dental health encounters through the designated Federally Qualified Health Centers (FQHCs). In SFY 2004 it was recognized that increasing access to quality preventive and primary care for the underserved and uninsured populations in New Jersey was critical. New Jersey focused efforts on building increased capacity among existing FQHCs, as well as making resources available to establish new access points in underserved communities. Over the next two years it is expected that an additional 100,000 individuals will have access to quality affordable health care through this expansion effort. Of the $10 million allocated in the SFY 2004 budget, $4.46 million is dedicated to capacity building for existing FQHCs, $3 million to establish new access points, and $1.5 million to outreach, education and marketing efforts. The remainder of the funds will be combined with the $12 million already dedicated to the support of reimbursement for uninsured primary care visits.

Children with special health care needs who are Supplemental Security Income (SSI) recipients or previously received a waiver of mandatory enrollment into an HMO, continue to be enrolled in managed care. The Title V Program through the Birth Defects Registry is collaborating with Medicaid to identify any child who may have special health care needs but is not on SSI. This is in order to ensure that the child and their family have access to any special services that would otherwise be available to that population, including case management services.

The State's budget for fiscal year 2005 includes continued funding of the NJ FamilyCare program

maintaining services and eligibility of children and pregnant women. However, health insurance alone is not sufficient to meet the ever growing needs of New Jersey's population. Title V services within FHS will continue to support enabling services, population-based preventive services, and infrastructure services to meet the health of all New Jersey's families. Title V will continue to maintain a safety net of services, especially for children with special health care needs. Even with reduced financial barriers to health care for children, challenges persist in promoting access to services, reducing racial and ethnic disparities, and improving cultural competency of health care providers and culturally appropriate services.

Both nationally and in New Jersey, obesity is a growing epidemic. The Department of Health and Senior Services has built a strong foundation to move forward and develop a comprehensive state nutrition and physical activity plan. At this point, the prevention and control of obesity and other chronic diseases through nutrition and physical activity is addressed through initiatives by staff in a number of programs throughout the Department and Division including perinatal health, family planning, child health and adolescent health, and senior services. Youth-focused nutrition and physical activity initiatives under development will use pedometers as a method to motivate youth to be more active, as well as track their progress through diaries. This will be implemented in youth serving organizations and in 10 school districts in collaboration with the NJ Department of Education. The New Jersey Council on Physical Fitness and Sports, an advisory body created by the State Legislature and staffed by DHSS, promotes the health of the citizens of New Jersey by developing safe, healthful and enjoyable physical fitness and sports programs. Recognizing obesity as a problem affecting all New Jerseyans, an Obesity Prevention Task Force was recently established through legislation. The purpose of the Task Force is to study, evaluate, and develop recommendations and specific actionable measures to support and enhance obesity prevention among New Jersey residents, particularly among children and adolescents.

Model Community Partnerships for Healthy Adolescents have been formed in nine communities to promote the adoption of healthy behaviors and the avoidance of risky behaviors, particularly regarding sexual behavior, prevention of injuries, nutrition and physical activity. The State continues to use Tobacco Settlement funds to support initiatives to prevent youth from starting to smoke.

Promoting healthy and safe early childhood programs has also been on the State's agenda. This past year, after receipt of the Early Childhood Comprehensive Systems grant from the Maternal and Child Health Bureau, the Division's child health program convened a planning team charged with development of an integrated approach to an early childhood support and delivery system. Working with a myriad of public and private agencies, New Jersey's challenge is to work as partners with Build NJ ? Partners for Early Learning and the National Infant Toddler Child Care initiative, two other grant supported projects with similar and complementary goals. The Healthy ChildCare New Jersey project has also continued to flourish, publishing newsletters, implementing a universal health form and providing ongoing educational opportunities for child care providers.

The Office of Minority and Multicultural Health, which produced three reports that contained recommendations to address minority health issues, is in the process of updating New Jersey's progress in implementing the recommendations that are designed to eliminating disparities and improving access to health care for minority populations. The original reports were the product of three summit conferences on minority health issues titled "The Health of Minorities in New Jersey: Part I ? The Black Experience", "The Health of Minorities in New Jersey: Part II ? The Latino Experience" and "The Health of Minorities in New Jersey: Part III ? Asian American Forum on Health". The reports are available at www.state.nj.us/health/commiss/omh.

Reduction of racial and ethnic disparities in health outcomes continues to be a priority in the Division of FHS with a focus on infant mortality and adolescent pregnancy. Many of the minority health report recommendations are being addressed by FHS, including a focus on cultural competency training. The NJDHSS, Division of FHS, was selected as one of five state Title V programs to participate in a Targeted Technical Assistance. The National Center for Cultural Competence at the Georgetown University Center for Child and Human Development conducted the Technical Assistance as part of

the Federal Maternal and Child Health Bureau Strategic Plan, with the objective of increasing the percentage of States that implement culturally competent policies, procedures, and practices to 100%. One of the major goals identified by the group for follow-up was the development of a statewide network. The first meeting of the newly formed network had representation from the NJ Department's of Human Services and Health and Senior Services, Early Intervention Collaboratives, Maternal and Child Health Consortia, The Boggs Center, Statewide Parent Advocacy Network (SPAN), NJ Protection and Advocacy, and the Developmental Disabilities Council. The mission of the group is to strengthen culturally competent services in the State of New Jersey for people with diverse needs, and to facilitate access by individuals, families, providers, and professionals to these services. People with diverse needs are defined as "those with varying abilities and disabilities, cultures, languages, and social and health care needs."

Although there has been progress in reducing infant mortality and teen births in all racial and ethnic populations, New Jersey is still concerned that the rate of black infant mortality over two and a half times the rate for white infants and the rate of black adolescent pregnancy is more than triple that of white teens. The Black Infant Mortality Reduction activities are continuing through seven grantees that support direct services to pregnant African American women. Highlights of the seven supported community based projects are also presented in Section IV.B. Perinatal Health Services is also continuing to collaborate with the local chapter of the March of Dimes on their prematurity campaign and will be co-sponsoring an upcoming statewide summit later this year.

The New Jersey's Newborn Biochemical Screening Program has now expanded from four disorders in early 2001 to its current twenty disorders. Beginning in October 2003, screening for six organic acidemias were added to the newborn screening panel of tests. This is a direct result of implementation of tandem mass spectrometry technology. New Jersey's state fiscal year 2004 budget did not include an appropriation for newborn screening follow-up, treatment and ongoing medical management of affected infants. However, the fee charged to hospitals for newborn screening services was increased to ensure adequate revenue is available to cover these vital services. There was no disruption of services to affected children and their families. Through support of a network of treatment centers, a safety net is provided to ensure that all affected children receive critically needed follow up and treatment services.

The newly established Office on Women's Health, in the DHSS, has been very active over the past year. The proceedings of the May 2003 summit, "Working Together for Comprehensive Women's Health" were published and distributed to all participants. This report will serve as a starting point for the Women's Health Commission once all member appointments are announced.

The Office on Women's Health successfully implemented a women and heart disease awareness campaign by supporting and coordinating with the Women's Heart Foundation in New Jersey. The first ever Women's Heart Walk is planned, and throughout the past year professional and public educational activities have been conducted. Collaboration is essential to the success of this office. To ensure ongoing communication and cooperative planning, an intradepartmental working group on women's health has been convened. The working group is comprised of representatives from all Division programs serving women.

B. AGENCY CAPACITY

The mission of the Division of Family Health Services (FHS) is to improve the health, safety, and well being of families and communities in New Jersey. The Division works to promote and protect the health of mothers, children, adolescents, and at-risk populations, and to reduce disparities in health outcomes by ensuring access to quality comprehensive care. Our ultimate goals are to enhance the quality of life for each person, family, and community, and to make an investment in the health of future generations.

The statutory basis for maternal and child health services in New Jersey is based first on the statutes passed in 1936 (L.1936, c.62, #1, p.157) authorizing the Department of Health to participate in receiving Title V funds for its maternal and child services which are existent at that time. Subsequently, when the State constitution and statutes were revised in 1947, maternal and child health services were incorporated under the basic functions of the Department under Title 26:1A-37, which states that the Department shall "Administer and supervise a program of maternal and child health services, encourage and aid in coordinating local programs concerning maternal and infant hygiene, and aid in coordination of local programs concerning prenatal, and postnatal care, and may when requested by a local board of education, supervise the work of school nurses."

Other statutes exist to provide regulatory authority for Title V related services such as: services for children with Sickle Cell Anemia (N.J.S.A. 9:14B); the Newborn Screening Program services (N.J.S.A. 26:2-119, 26:2-111 and 26:2H5); genetic testing, counseling and treatment services (N.J.S.A. 26:5B-1 et. Seq,); services for children with hemophilia (N.J.S.A. 26:2-90); the birth defects registry (N.J.S.A. 26:8-40.2); the Catastrophic Illness in Children Relief Fund (P.L. 1987, C370); the childhood lead poisoning prevention program (Title 26:2-130-137); and the SIDS Resource Center (Title 26:5d1-4). Recent updates to Title V related statutes are mentioned in their relevant sections.

The following is a description of New Jersey's Title V capacity to provide preventive and primary care services for pregnant women, mothers and infants, preventive and primary care services for children, and services for CSHCN.

III. B. 1. Preventive and Primary Care for Pregnant Women, Mothers and Infants

The mission of Maternal, Child and Community Health Service (MCCH) within FHS is to improve the health status of New Jersey families, infants, children and adolescents in a culturally competent manner, with an emphasis on low income and special populations. The Perinatal Health Services Program, within MCCH, coordinates a regionalized system of care of mothers and children through the seven Maternal and Child Health Consortia (MCHC). The MCHC were developed to promote the delivery of the highest quality of care to all pregnant women and newborns; to maximize utilization of highly trained perinatal personnel and intensive care facilities, and to promote a coordinated and cooperative prevention-oriented approach to perinatal services. Continuous quality improvement activities are coordinated on the regional level by the MCHC. The MCHC regional plans now include pediatric need assessments and an inventory of resources including directories of providers.

The Black Infant Mortality Reduction activities are also being administered and coordinated by the Perinatal Services Program including the Resource Center and development of community-based programs and services. Several related activities including cultural competency training are a division-wide effort.

The eight funded Healthy Mothers, Healthy Babies (HMHB) Coalitions continue to reduce infant morbidity and mortality through outreach and education. The HMHB Coalitions act as the Community Action Teams for Fetal Infant Mortality Review (FIMR) project.
/2005/ In this role some Coalitions have chosen projects based on the FIMR results. Trenton, New Brunswick and Plainfield identified a need for consistent prenatal care and developed an outreach program to locate clients "lost to care" and reconnect them to services. Jersey City identified a need for preconceptional health, education and designed a campaign to educate both providers and consumers on exercise and nutrition. Paterson identified a need for peer counseling for pregnant and parenting teens and developed a program.//2005//

The HMHB Coalitions all provide formal and informal outreach worker training. Training topics include: immunizations, personal safety, lead screening, domestic violence, child growth and development, dental health, AIDS, asthma, smoking cessation, BIMR, cultural competency, home safety, car safety, fatherhood, postpartum depression, mental health, stress reduction, addictions, parenting and other topics identified by the outreach workers.

Outreach activities range from door to door canvassing to large community events. The HMHB Coalitions sponsor community events such as Baby Showers, Baby Safety Showers, "Pregnant Pause" and Health Fairs; school based events such as the "Game of Life" and Teen Awareness Days and presentations for community groups and faith-based initiatives. Outreach efforts are also conducted wherever women may gather such as grocery stores, hair and nail salons, laundromats and clinics.

HMHB Coalition activities include the hiring of multicultural, multilingual staff and the recognition of changes in existing client bases. The New Brunswick Coalition has seen an increase in the Mexican population, the Paterson Coalition an increase in the Arab population and the Camden Coalition in the Latino population. Religious affiliations are also changing with increases in the Muslim and Hindi populations. In addition to cultural changes the family unit is also changing-increased single father households, increased multiple births, increased adolescent pregnancies and an increase in grandparents raising grandchildren. The Coalitions are responding by attempting to increase Coalition membership from these groups. Professional and consumer education is also being expanded to include the unique needs of the population.

Fetal Alcohol Syndrome Prevention and Perinatal Addiction Services are also a part of the Perinatal Health Services Program and are further discussed in Section III.E. State Agency Coordination.

III. B. 2. Preventive and Primary Care for Children and Adolescents

The Child and Adolescent Health Program, within MCCH, focuses on preventive initiatives in the areas of lead poisoning, immunization, injury prevention, risk reduction, oral health, nutrition and physical fitness. Special emphasis has been placed on outreach and education of health care providers and the public, to ensure the screening of children under six years of age for lead poisoning. Home visiting activities continue through the Prevention Oriented System for Child Health (POrSHE) program. Preventive Oral Health education and a fluoride mouth rinse program in the highest risk schools are provided through support of three regional programs. There are on-going planning efforts to address early childhood comprehensive systems, comprehensive school health, and health and safety issues in child care facilities. The Adolescent Health section continues to work on reduction of adolescent pregnancy, intentional and unintentional injuries, and improved nutrition and fitness. The MCCH unit continues to be very active in NJ FamilyCare outreach and enrollment activities.

III. B. 3. Preventive and Primary Care for Children with Special Health Care Needs

Special Child, Adult, and Early Intervention Services (SCAEIS) ensures that all persons with special health needs have access to comprehensive, community-based, culturally competent and family-centered care. A priority for SCAEIS is ensuring rehabilitative services for blind and disabled individuals less than 16 years old receiving services under Title XIX. SCAEIS receives monthly printouts from the Social Security Disability Determination Unit that identify all children applying for Social Security Insurance (SSI). Copies of the printouts are sent to the appropriate County Case Management Units. County Case Management Units outreach to all SSI applicants to offer information, referral, and case management services. In addition, Individual Service Plans that address the medical, dental, developmental, rehabilitative, social, emotional, and economic needs of the child and/or family are developed. Periodic monitoring of needs and progress toward attaining services are also conducted.

Although not directly supported by Title V funds, a statewide family service network for children and their families affected by HIV are also administered within SCAEIS.
/2005/ This network, consisting of seven sites, has enabled service to over 4,400 clients in 2003. In addition, during this past year, enrollment of 136 children, 62 adolescents and adult women, and 5 men into clinical trials has been facilitated through network operations. Through Robert Wood Johnson Medical School, the Network employs a Community Liaison to publicize the Network, provide education related to HIV disease management for consumers and providers, and provide linkages for clients to ancillary services. //2005//

SCAEIS works with parent groups, specialty providers and a statewide network of case managers to provide family-centered, community-based, coordinated care for Children with Special Health Care Needs (CSHCN) and facilitate the development of community-based services for such children and their families. In SFY 2002, the Statewide Parent Advocacy Network (SPAN) funded through SCAEIS continued to provide parent support through a three-pronged approach titled Family WRAP (Wisdom, Resources, Advocacy and Parent-to-Parent). Specific Family WRAP programs include Project Care, Parent-to-Parent and Family Voices New Jersey.

Project Care, in existence since 1986, provides statewide family support by fourteen paid parents of CSHCN housed in 11 County Case Management Units. In addition, financial support through Project Care partially subsidized the annual SPAN conference for CSHCN.
/2005/ In SFY 2003, nearly 500 families attended the 2-day conference. SCAEIS staff provided information on case management, New Jersey FamilyCare, newborn biochemical and hearing screening, Early Intervention Services, and other programs and services for CSHCN.//2005//
Parent support is also provided through the Parent-to-Parent program.

Parent-to-Parent is a telephone support service that matches trained volunteer support parents with other parents of children who have similar health care needs.
/2005/ Nearly 75 support parents were trained in SFY 2003 and 145 matches were made.//2005//

The third program within Family WRAP, Family Voices New Jersey (FVNJ), focuses on education, advocacy, medical home, and expanded outreach to families of CSHCN.
/2005/ The New Jersey Coordinators of FVNJ provided training programs in SFY 2003 to approximately 180 parents and professionals, one-on-one technical assistance to nearly 130 parents, and telephone assistance to nearly 280 parents. A brochure describing Family WRAP is provided to each family served through the county case management units.//2005//

SCAEIS and SPAN have successfully collaborated to apply for supplemental funding for Family WRAP activities from local philanthropic organizations including the Essex Healthcare Foundation targeting Essex County and the Van Houten Foundation targeting Bergen and Passaic efforts, and the Health Resources Services Administration's Early Hearing Detection Intervention (EHDI) project.
/2005/ In FY 2003 Family WRAP's involvement with New Jersey's EHDI project included targeted outreach to parents, organizations, and agencies that provided family support to children who are deaf or hard of hearing; trained 7 volunteer support parents of children that are deaf and/or hard of hearing; and developed a flyer (in English and Spanish) to educate parents about newborn hearing screening follow-up.//2005//

C. ORGANIZATIONAL STRUCTURE

The organizational structure of the New Jersey Title V program has not changed since the submission of the FFY 2002 application. All Maternal and Child Health (MCH) programs including programs for Children with Special Health Care Needs (CSHCN) continue to be organizationally located within the Division of Family Health Services (FHS). All Title V services are under the direction of Celeste Andriot Wood, Assistant Commissioner, Division of FHS. The Division of Family Health Services is one of three divisions that compromise the Department's Public Health Service section. The other divisions are: AIDS Prevention and Control and Addiction Services. The three divisions are under the direction of a Deputy Commissioner.
/2005/ NJ's child welfare and protection system under the State DHS has completed a child welfare reform plan. As a result of weeping reforms to ensure the safety, permanency and well being of NJ's children, the Division of Addictions is being administratively transferred to DHS to improve coordination of services and efficiency in administration.//2005//

The organizational structure chart for the New Jersey Department of Health and Senior Services is attached to the III. A. Overview section.

The organizational structure chart for the Division of Family Health Services is attached to this section - III. C. Organizational Structure.

D. OTHER MCH CAPACITY

Maternal and Child Health Epidemiology Program
The Maternal and Child Health Epidemiology Program (MCH Epi) is under the direction of Lakota Kruse, M.D., M.P.H., Medical Director for the Division of Family Health Services. The Office of the Medical Director provides medical and epidemiological consultation for all the division's programs. The mission of MCH Epi is to promote the health of pregnant women, infants and children through the analysis of trends in maternal and child health data and to facilitate efforts aimed at developing strategies to improve maternal and child health outcomes through the provision of data and completion of applied research projects.

The MCH Epi Program promotes the central collection, integration and analysis of MCH data. Ingrid Morton is the Program Manager for MCH Epi, which is comprised of four research professionals, and three support staff. All research staff members possess extensive experience in statistics, research, evaluation, demography and public health. Additionally, professional staff members have extensive experience with data linking, record matching and epidemiological research. One professional staff position is supported entirely by resources from the MCH Bureau's State Systems Development Initiative (SSDI) grant.

Maternal, Child and Community Health

MCCH is comprised of three program managers, 39 professionals, and 24 support staff. All staff members are housed in the central office. Among the professional staff are individuals with nursing, social science, environmental, nutrition, statistical, epidemiology, and other public health backgrounds. MCCH has three major programs: Perinatal Services, Reproductive Health, and Child and Adolescent Health. Administratively reporting out of the Office of the Director is the Primary Care Coordinator and the coordinator for Federally Qualified Health Center (FQHC) Expansion Program Activities.
/2005/ Dr. Linda Jones-Hicks became the new Service Director for MCCH in January 2004. Dr. Jones-Hicks is a pediatrician with specialty training in Adolescent Medicine and experience with several MCH coalitions in New Jersey.//2005//

The Perinatal Health Services program is staffed by nine professionals and five support personnel and a Program Manager, Sandra Schwarz. The program is responsible for the regional MCH Consortia, Healthy Mothers/Healthy Babies Coalitions, Certificate of Need rules and MCH Consortia regulations, morbidity and mortality reviews, Healthy Start projects, the HealthStart comprehensive maternity services, the Black Infant Mortality Reduction Initiative, perinatal addictions and fetal alcohol syndrome prevention projects, and preconceptual health. Resources for staff have been from Federal MCH Block, Preventive Health and Health Services Block, and Healthy Start Grants.

The Cancer and Reproductive Health Program interacts extensively with the other Title V programs. The Cancer and Reproductive Health Services program is comprised of a staff of 12 professionals and four support personnel and a Program Manager, Doreleena Sammons-Posey. Reproductive Health Services is responsible for the Family Planning Program (Title X) and the New Jersey Cancer Education and Early Detection Program (NJCEED). Resources for staff and programs have been from Federal Title X, Social Services Block Grant, Federal MCH Block, State, and CDC Cooperative Agreement funding sources.

The Child and Adolescent Health Program is comprised of a staff of 17 professionals, 9 support personnel and a Program Manager, Kevin McNally. Resources for staff have been from State, Federal MCH Block Grant, Preventive Health and Health Services Block Grant and Centers for Disease Control and Prevention grants. All staff members are housed in the central office. Child and Adolescent Health is divided into early childhood and adolescent health sections. The early childhood section has a coordinator and eight professionals. The adolescent health section is headed by a coordinator with a staff of three professionals. The Abstinence Education coordinator and the School and Oral Health coordinator are also members of the Child and Adolescent Health staff. Child and Adolescent Health staff have varied professional backgrounds including nursing, nutrition, family counseling, health education, environmental health research and data analysis.

Special Child, Adult, and Early Intervention Services (SCAEIS)

In September 2002, Gloria Rodriguez assumed the role of Director of Special Child, Adult, and Early Intervention Services (SCAEIS). SCAEIS consists of the following programs and services: Early Identification and Monitoring, Newborn Screening and Genetic Services Program, Family Centered Care Services, Child and Adult Special Services, and Early Intervention Services. All SCAEIS staff members are housed in the central office.

Early Intervention Services is headed by Terry Harrison. This program provides services to infants and toddlers with disabilities or developmental delays in accordance with Part C of the Individuals with Disabilities Education Act.

The Early Identification and Monitoring (EIM) Program is responsible for the reporting and monitoring of children with birth defects and special needs (the Special Child Health Services Registry), Early Hearing Detection and Intervention, the New Jersey Center for Birth Defects Research and Prevention and the National Down Syndrome Study. The EIM Program is comprised of a staff of ten professionals, seven support staff, and a Program Manager, Leslie Beres-Sochka, who holds a Master of Science in biostatistics and has 20 years experience in research, statistical analysis, and database design and management. Resources for staff come from the MCH Block Grant, a HRSA grant for universal newborn hearing screening, and two Centers for Disease Control and Prevention cooperative agreements.
/2005/ An additional 4 year CDC cooperative agreement was awarded to the EIM Program in September 2003. This funding will be utilized to enhance data linkage and exchange between the SCHS Registry and the Family Centered Care Program.//2005//

The Newborn Screening and Genetic Services Program is responsible for the follow-up of all newborns having been identified with abnormal screening results. This program is also responsible for the oversight and administration of several specialty care centers for metabolic and genetic services, pediatric endocrine services, pediatric hematologic services, pediatric pulmonary services and specialized confirmatory and diagnostic laboratory services. The program is comprised of a staff of 10 professionals, three support staff and a Senior Public Health Physician, Dr. Marilyn Gorney-Daley.
/2005/ The Newborn Screening and Genetic Services Program is comprised of a staff of 9 professionals, three support staff and a Program Manager, Mary R. Mickles. Ms. Mickles is a Registered Dietitian, holds a master's of Science degree in Nutritional Science and has extensive experience in management and public health. Resources for staff as well as specialized pediatric treatment programs are provided through an Inborn Error of Metabolism Laboratory fee and state designated appropriation. Dr. Gorney-Daley resigned her position with the Department on December 6, 2003, and a pediatric consultant for the unit is currently pending appointment.

The Family Centered Care Program is responsible for funding, monitoring, and evaluating services provided by the 21 Title V funded case management units, Family WRAP family support services, 11 child evaluation centers, 5 cleft lip/cleft palate centers, 3 tertiary care centers, and the 7 Ryan White Title IV funded Statewide Family Centered HIV Care Network sites. Resources for staff come from the MCH Block Grant and from the HRSA AIDS Bureau

under Ryan White Title IV. This program is comprised of a staff of eight professionals, four support staff, and a Program Manager, Ms. Diane DiDonato.
/2005/ Mrs. Diane DiDonato retired from State service on June 30,2003. Mrs. Pauline Lisciotto, RN, MSN and Public Health Nurse Consultant with the Family Centered Care, Case Management unit for ten years, has assumed the Program Manager role. Staff is comprised of seven professionals, and four support staff. The unit is recruiting for a Public Health Nurse Consultant to replace Mrs. Lisciotto.//2005//

As noted above, specialized pediatric services are now the responsibility of the Family Centered Care Program. A separate program to address adult health and chronic disease prevention has been established within the Special Child, Adult and Early Intervention Services unit. The unit is currently recruiting for a program manager for this program due to the retirement of Ms. Elizabeth Congdon in June 2002.

All programs within SCAEIS have staff with varied professional backgrounds including nursing, medicine, physical therapy, epidemiology, speech pathology, public health, research, statistics, family counseling, education, and genetic counseling. Both senior level and support staff includes parents of children with special health care needs such as developmental delay, seizure disorder, specific genetic syndromes, and asthma.
/2005/ In 2004, the EIM Program has hired staff with expertise in audiology and toxicology.//2005//

E. STATE AGENCY COORDINATION

New Jersey has prided itself on its regional MCH services and programs, which have been provided through the Maternal Child Health Consortia (MCHC), an established regionalized network of maternal and child health providers with emphasis on prevention and community-based activities. The consortia are charged with developing regional perinatal and pediatric plans, total quality improvement systems, professional and consumer education, transport systems, data analysis, and infant follow-up programs. Specific programs include the activities of eight Healthy Mothers/Healthy Babies Coalitions, Perinatal Addictions Projects, preconceptional health counseling, regional Childhood Lead Poisoning Prevention Coalitions, and facilitation of the Black Infant Mortality Reduction initiative. These activities have continued to expand during the reporting period and have gained the attention of other department programs.

A representative from Perinatal Health Services serves as the liaison to three of the New Jersey Healthy Start Projects (Atlantic City, Camden and Trenton) and is responsible for the collaboration and coordination of the New Jersey Healthy Start Projects with Department activities and programs. This collaboration will help to assure integration of services and the effective use of both State and Healthy Start funds to eliminate disparities in women's and infant's health. The Atlantic City and Camden projects are funded through the Southern New Jersey Perinatal Cooperative and the Trenton project is funded through the City of Trenton Department of Health.

The DHSS has seats on both the Child Fatality and Near Fatality Review Board (CFNFRB), which is in, but not of, the Department of Human Services, Division of Youth and Family Services, and the Domestic Violence Fatality Review Board, Department of Community Affairs, Division on Women. Staff from Perinatal Health Services represents the Commissioner of Health and Senior Services on these boards. A major outcome of the relationship with the CFNFRB is to work towards a coordinated effort of mortality/morbidity review in New Jersey.

Staff from Perinatal Health Services participate in the Steering committee for Promoting Safe and Stable Families (Title IV-B) within the Department of Human Services. Efforts continue to enhance and increase the community-based delivery of family-preservation, family support, time-limited family re-unification and adoption promotion and support services.

Fetal Alcohol Syndrome (FAS) prevention is an area where the MCCH and SCAEIS programs are collaborating with the Department of Human Services. Through the Office of Prevention of Mental Retardation and Developmental Disabilities (OPMRDD), the FAS Task Force was convened to assess and make recommendations regarding FAS prevention. Staff from both units participate on the Task Force, which developed a white paper on the subject. MCCH hopes to use the Task Force report as a basis for modifying prevention programs and services to better reach women at risk.

In SFY 2002, state funds became available for establishment of prevention, diagnosis and treatment centers for Fetal Alcohol Syndrome (FAS). In SFY 2003, $450,000 was again awarded to SCAEIS, Specialized Pediatric Services, to continue the Centers of Excellence for diagnosis, treatment, and education. With these funds, four child evaluation centers (2 are multi-agency collaborative projects), continue to function as centers of excellence and in FY 2003, one center also received a CDC regional centers grant to develop a core curriculum to be used nationwide to educate health care professionals on FAS. The staff of the Centers are in contact with the FAS Task Force, the MCH Consortia, the Department of Education, The ARC, and other state and community agencies who serve the FAS community. Additional funds in the amount of $400,000 were awarded to the Perinatal Health Services Program for the Perinatal Addictions Coordination project through the MCH Consortia. This program provides for professional and community education regarding the use and abuse of alcohol, drugs and tobacco during pregnancy. This regional approach reaches both the public and private sector providers of care to ensure access to risk reduction assessment and intervention.
/2005/ The 30th Anniversary Conference titled, "The Truth and Consequences of Fetal Alcohol Syndrome" co-sponsored by the Centers for Disease Control and Prevention (CDC), New Jersey Department of Health and Senior Services, and others was held on October 27-28, 2003 in Atlantic City. The Perinatal Health Services Program staff took an active role in this conference by serving on the Planning Committee, functioning as Workshop Moderator and Exhibitor. Through the two-day national conference, the program displayed and distributed 1,500 brochures related to alcohol, drugs and stress in pregnancy. The conference attracted, approximately, 250 health care professionals from throughout the United States and other countries.//2005//

Teen pregnancy prevention is at the forefront in New Jersey. The Advisory Council on Adolescent Pregnancy Prevention held its first meeting in April 1999. The Council is in, but not of, the Department of Health and Senior Services. Representation includes designees from the Departments of Human Services, Education, Community Affairs, and Labor. Some of the Council's responsibilities include development of policy proposals, promoting a coordinated and comprehensive approach to the problems of adolescent pregnancy and parenting, and promoting community input and communication. The Council has established working groups on data, male involvement, school-based services and teen parenting. In 2003, the Council developed a three-year strategic plan to guide the work of the Council and focus on specific areas of interest.

The WorkFirst Teen Pregnancy Prevention Work Group is another example of successful interdepartmental collaboration. The Department of Human Services serves as lead agency for this initiative and the group has been charged with planning, developing and implementing new initiatives. Using TANF grant funds, $1.1 million was allocated for Teen Pregnancy Prevention Initiatives. Youth-to-youth programs and mentoring projects are now underway and a Teen Pregnancy Resource Center has been established. MCCH staff participate along with representatives of the Departments of Human Services and Education. MCCH also has the responsibility for the State's Abstinence Only Program.

More emphasis is also being placed on facilitating health and safety in childcare settings. Collaboration between the DHSS and the New Jersey Department of Human Services, Division of Family Development over the past four years has resulted in the establishment of an infrastructure to promote the health and development of young children in childcare settings. A position for a health consultant nurse has been created in the childcare coordinating agencies in every county. Nurses

from local health departments and other community agencies are being trained to be health consultants to their local child care providers. Staff from the two Departments collaborated with the State chapter of the American Academy of Pediatrics in obtaining a Federal Healthy ChildCare America Grant to support this initiative. This year the 13th Annual Health in ChildCare Conference will be held in June.
/2005/ In January 2004 the DHSS initiated a process to develop an Early Childhood Comprehensive Systems (ECCS) Plan for New Jersey. This planning process is supported by a federal State Early Childhood Comprehensive Systems grant. Partners with DHSS on the ECCS Planning Team include the New Jersey departments of Human Services, Education, Community Affairs, Environmental Protection, and Labor, and the Juvenile Justice Commission. Community partners include the Association for Children of New Jersey, the Youth Consultation Service, Healthy Child Care New Jersey, Children's Futures, and the University of Medicine and Dentistry of New Jersey. The Planning Team also includes three parent members. To facilitate the process, the ECCS team is collaborating with an existing statewide program, the BUILD New Jersey Partners for Early Learning initiative.//2005//

The oral health component of the Child and Adolescent Health Program is working cooperatively with the New Jersey Dental Society (NJDS) on oral health education activities and the promotion of fluoride mouth rinse programs in schools in communities without fluoridated water. The DHSS also collaborated with the NJDS and the University of Medicine and Dentistry of New Jersey (UMDNJ) - New Jersey Dental School in the planning of the New Jersey Oral Health Summit held in September 2001, and the formation of the New Jersey Oral Health Coalition. The Coalition has continued to meet regularly and to develop strategies to implement the recommendations that were developed at the Summit.

School health collaboration and coordination is accomplished through a school health liaison position within the Child and Adolescent Health Program. In December 2000, a joint planning effort among the staff of the Departments of Education and DHSS resulted in a Strategic Plan for School Age Health signed by both Commissioners. The strategic plan affirms both departments' support for comprehensive school health programs, with a particular focus on the 31 special needs school districts. Staff also collaborated on specific projects, including review of health and physical education standards, development of a protocol for emergency administration of epinephrine, the development and distribution of video and lesson plans on nutrition and physical exercise and a training program on asthma for school nurses.
/2005/ A retreat in January 2004 brought together key staff from the three Departments to assess progress in the implementation of the Strategic Plan and to begin a process of revising and updating it to reflect current needs and priorities.//2005//

The injury prevention specialist in the Child and Adolescent Health Program participates in the Northeast Injury Prevention Network, a collaborative of the six New England states, New York, and New Jersey. Activities in the past year have focused on suicide prevention, including producing a suicide data book covering the eight states, and suicide prevention plans for each of the states. Network activities for 2002-2003 are focusing on poisoning prevention.

The DHSS participates in the New Jersey Interagency Task Force on the Prevention of Lead Poisoning. Other participating organizations include the State Departments of Human Services, Community Affairs, Environmental Protection, Banking and Insurance, and Labor, as well as statewide professional, academic, and community-based organizations. During 2002-03, the task force developed a Strategic Plan for addressing lead poisoning in New Jersey.
/2005/ In 2003-04, the Strategic Plan is being used as the basis for the development of a Plan for the Elimination of Childhood Lead Poisoning in New Jersey. The Task Force has also sponsored a number of professional and public education activities, including an annual statewide celebration of Childhood Lead Poisoning Prevention Week in October of each year, and the Lead Exploratorium, a mobile exhibit on dealing with lead hazards in the home.//2005//

/2005/ An increased state appropriation for lead poisoning prevention in 2002-03 has enabled

the funding of four regional childhood lead poisoning prevention coalitions. The coalitions, which cover the entire State, promote community-based activities to prevent lead poisoning in children. They are supported by an allocation of $220,000 in State funds. The MCHCs play a major role in coordinating these coalitions, along with local health departments and community-based partners. Public education activities conducted in the first year included sponsorship of local events, billboards, PSAs in movie theaters and on cable TV, and education of child care providers.//2005//

In January 2002, an Interdepartmental/Asthma Working Group was formed. Representatives from several Divisions and Services in DHSS (Family Health Services, Epidemiology, Environmental and Occupational Health, the Center for Health Statistics, and the Office of Minority and Multicultural Health), as well as from the Departments of Human Services, Environmental Protection, and Education actively participate. The Working Group has developed a plan for coordination of State government activities to address asthma in New Jersey.
/2005/ The plan was completed and endorsed by each of the participating State agencies in July 2003. Staff from DHSS and other State agencies have also participated, through the Pediatric/Adult Asthma Coalition of New Jersey, in developing "The Pathway to Asthma Control in New Jersey", a strategic plan for public/private collaboration to address asthma in this State.//2005//

Coordination between the State's Primary Care Association and Federally Qualified Health Centers continues. The Coordinator of Primary Care works out of the Office of the Director, Maternal, Child, and Community Health Services; the Federal Primary Care Cooperative Agreement is administered by Maternal, Child, and Community Health Services.

In collaboration with Rutgers University, department representatives, and the MCH Consortia, MCCH developed an evaluation survey to assess the efficiency and efficacy of the MCH Consortia model. A survey was developed and administered across all consortia to include many diverse constituency groups including hospitals, community groups, clinical professionals, and consumers. Areas evaluated include constituent satisfaction, cost effectiveness, performance standards and other related issues. Major issues included geographic boundaries, funding and regulatory issues. Most constituents provided positive feedback regarding the consortia model. Prevalent suggestions to increase the effectiveness of the consortia included diversification of the membership and leadership, diversification of funding sources, and redesign of the geographic boundaries. Currently, consortia boundaries are based on hospital referral patterns and catchment areas that in several cases overlap among consortia. In response to the report, and growing concerns about the outlook and funding challenges in the current environment, a working group was convened in October 2002 to review and make recommendations to the Department regarding regulatory issues. The MCHC Working Group conducted a series of meetings to promote a robust discussion about the future of the Maternal Child Health Consortia. An Executive Director and a senior board member represented each of the seven consortia.

The MCHC Working Group meetings provided an opportunity to consider concerns relative to the future structure of the Consortia. The group attempted to identify areas of general agreement and consensus. Dissenting opinions were aired and noted. The key goal was to develop a set of criteria and priorities that could be presented to the Commissioner of DHSS as an aide in the establishment of new policy relative to improving maternal and child health in the state. The Working Group addressed both structural and funding issues. After a full discussion, the majority of the participants agreed to present the following constructs to the MCHC boards for full consideration and feedback.
/2005/ The Working Group addressed a preliminary exploration of the future of the MCHC system; ensuring that it continues to be relevant, responsive, and effective while acknowledging the financial realities and concerns of all constituents and funding sources. The Working Group devised three basic models for the future structure of the consortia system including four, three, and seven consortia regions. The Report also proposed geographic boundaries for the respective models. Based on the discussions of the Working Group the Gateway MCH Consortium headquartered in Newark and the Northwest New Jersey

MCH Network headquartered in Morristown merged effective January 1, 2004. This merger brings the number of consortia to six.//2005//

A Maternal and Child Health Task Force on hospital-based perinatal and pediatric services is planned. The Task Force will, within one year of its formation, examine New Jersey's planning and regulatory requirements for the provision of the total range of perinatal and neonatal/infant services, with special emphasis on the issues of quality, cost and access to services (including CPC's and RPC's; PICU's and MCH Consortia). The Task Force will examine changes in clinical practice over the past decade, and the implications, if any, for the regulatory structure. As part of its charge, the Task Force will review regulatory structure and organization of the system of hospital-based perinatal, neonatal/infant, pediatric services in other states, either demographically similar to New Jersey, or considered to be leaders. Finally, the Task Force will develop public policies regarding appropriate preventive, primary, and tertiary hospital-based pediatric services, with special emphasis on the statewide system of pediatric hospital based care.
/2005/ The MCH Task Force on hospital based perinatal and pediatric services has been delayed due to difficulties in contracting with a consultant to facilitate the group. Currently, Perinatal Health Services staff members are conferring with staff in Certificate of Need and Licensure on a case by case basis for certificate of need and licensure issues.//2005//

Special Child, Adult and Early Intervention Services (SCAEIS) and the Statewide Parent Advocacy Network (SPAN) continue to collaborate to improve services to CSHCN, including transition to adulthood services. The Essex County SPAN Resource Specialist, (parent of a CSHCN) initiated a pilot project on transition to adulthood. It is intended to augment transition to adulthood services currently provided for families served through the Essex County Case Management Unit.
2005/ The Essex County SPAN Resource Specialist, (parent of a CSHCN) initiated a pilot project on transition to adulthood intended to augment transition to adulthood services currently provided for families served through the Essex County Case Management Unit. The project involved outreach to families at about age 12 (telephone and/or a letter), support in accessing transition services, development and distribution of a transition to adulthood packet, which included information on topics such as Family WRAP, Section 504, and the Individualized Health Plan. Positive family feedback indicated that this initiative was beneficial and needed. Although funding from the Essex Healthcare Foundation ended in December 2002, SCAEIS continued to support this project through the end of SFY 03. As a result of this transition to adulthood pilot, the 21 county Case Management Units are using the Essex County transition packet as a model to develop county specific packets for distribution to age appropriate children served through their units.***//2005//***

To assist families of children with special needs in navigating the Medicaid Managed Care system a Medicaid Managed Care Alliance was formed in October 1999. This alliance is comprised of parents, advocacy groups, representatives from the DHS Office of Managed Care, NJ FamilyCare, HMO case managers, SCAEIS case managers and others. The Medicaid Managed Care Alliance continues to meet approximately annually. It promotes collaboration between HMO case managers and the County Case Management Unit staff which has proven valuable in problem solving access to appropriate specialized pediatric services, payments for non-covered medical and or social services for CSHCN, and smoother transition between systems of care such as Early Intervention, Medicaid model waivers, and special education. In October 2002, Medicaid Managed Care Alliance members were invited to participate in a meeting focusing on the reorganization of SCAEIS services and ongoing efforts to achieving community based systems of care for CSHCN and their families. This meeting successfully linked SCAIES state staff and grantees with parents, Medicaid HMO case managers and the Department of Human Services Quality Assurance and Monitoring staff, and led to closer working relationships at the county and provider agency level.

In May 2001, SCAEIS partnered with the Department of Human Services, Division of Deaf and Hard of Hearing (DDHH) and the MCH Consortia to conduct three, one-day training seminars for newborn hearing screening. The training conferences conducted by national experts in hearing screening, provided guidance and hands-on training for hospital staff, physicians, and

audiologists on the new rules and screening equipment. In January 2002, new legislation was enacted to strengthen the mandate to universally screen all newborns for hearing loss. /2005/ SCAEIS has a seat on the Division of the Deaf and Hard of Hearing's (DDHH) Advisory Council. EIM Staff and staff from the DDHH have implemented quarterly meetings in order to coordinate and implement activities to strengthen the Early Hearing Detection and Intervention Program.//2005//

The "Children's System of Care" initiative has been initiated in three (3) counties, which will be a new system of comprehensive services for children with mental illness or severe emotional and behavioral problems. State funds of $39 million have been committed to create this centralized system. SCAEIS staff both welcome and anticipate collaborative efforts regarding this initiative. Currently, SCAEIS staff is represented on the Community Mental Health Board and Planning Council.

Through the activities of the New Jersey Center for Birth Defects Research and Prevention, staff from SCAEIS are building collaborative relationships with numerous agencies, such as the University of Medicine and Dentistry in New Jersey (Newark and New Brunswick facilities), the New Jersey School of Public Health, the Children's Hospital of New Jersey at Newark Beth Israel Medical Center, the Environmental and Occupational Health Sciences Institute, Rutgers University, and the NJDHSS Division of AIDS. Additionally, Centers' staff has developed a strong network with the other ten national Centers and other researchers. The focus of the collaborations has been to improve the surveillance of birth defects and to initiate a variety of research projects to further the understanding of the causes of birth defects. Among the funded projects is the formation of a fetal abnormality registry, which will document the occurrence of birth defects among pregnancies as opposed to live births. This data is critical for calculating accurate rates of the occurrence of birth defects, including better information on the evaluation of the impact of folic acid on pregnancies affected by neural tube defects. An example of a local research projects is the hypercoagulability study.

F. HEALTH SYSTEMS CAPACITY INDICATORS

Prior guidance for the MCH Block Grant specified a set of "core health status" indicators, which were required to be reported each year. Many States have used most of the core health status indicators to monitor their progress in improving or maintaining their primary care infrastructure. These "core health status" indicators (formerly core health status indicators #1, #2, #3, #6, #7 and #8) and one developmental health status indicator (#4) are now referred to as "health systems capacity" indicators. These "health systems capacity" indicators will be reported annually under the new guidance.

#1 HSCI - The rate of children hospitalized for asthma (10,000 children < 5)

/2005/ DHSS is a member of the Pediatric/Adult Asthma Coalition of New Jersey (PAC/NJ). PAC/NJ is organized by the American Lung Association of New Jersey and the New Jersey Thoracic Society. It has developed a Strategic Plan to address asthma in New Jersey, and has formed six task forces to develop and implement activities to achieve the objectives of the Plan. //2005//

Significant accomplishments to date include establishment of a PAC/NJ website, toll free number, and fact sheet; the development of a model Asthma Action Plan form and accompanying educational brochure; dissemination of the 38,000 copies of the Asthma Action Plan to schools; development of the "Stepwise Approach to Asthma Management," a single-page summary for physicians of the NHLBI Guidelines for asthma care; distribution of the summary to pediatricians, family practice physicians, and emergency room physicians along with the "Asthma Action Plan;" broadcasting of a training program that reached 248 school nurses; packaging and distribution of a video tape of the broadcast and other educational materials in a resource kit for school nurses, distribution of 189 "Health Hop -- Asthma Stuff" CD's to school nurses; development and pilot testing of a classroom video which is to be distributed to schools; development of a public information card on the "Top Ten Things You Can Do to Reduce Asthma Triggers in the Home," distribution of 10,000 "Top Ten?" cards to schools and 14,500 cards through Eckerd Pharmacies, DHHS staff participate on the Steering

Committee of the Coalition, as well as on the School, Child Care, Education, and Health Insurance task forces.

/2005/ At the invitation of the Institute of Medicine, Division of the National Academies of Science, PACNJ sent a four member team, including a DHSS representative, to the Crossing the Quality Chasm Summit in Washington in January 2004. PACNJ was one of four asthma projects from across the nation invited to participate in the summit.//2005//

A grant from CDC has been used to create a surveillance position in the MCH Epidemiology Program. The Research Scientist has developed a database on asthma mortality and hospitalizations, using data from the Vital Statistics and Hospital Discharge reporting databases. Information from the database was used to develop a summary report on "Asthma in New Jersey", published in February 2002. This data is also made available to the PAC/NJ task forces for planning and evaluation purposes.

/2005/ The annual "Asthma in New Jersey" summary report was updated May 2004 on the DHSS website. Due to an increase in federal funding level, two additional asthma positions will add to the Division of Family Health Services' Chronic Disease program. With additional staff, asthma infrastructure and program planning and implementation will be enhanced.//2005//

In 2002, the DHSS formed an Interdepartmental Working Group on Asthma. With the participation of staff from the Departments of Education, Human Services, and Environmental Protection, the working group prepared a strategic plan for the activities of New Jersey State Government in addressing asthma.

/2005/ The Strategic Plan was signed by the Commissioner of Health and Senior Services in July 2003.//2005//

The New Jersey Special Child Health Services Registry allows for the voluntary reporting of asthma as a chronic condition in children. Children registered are referred to the Family Centered Care Program, which provides case management assistance to the families through the county-based Special Child Health Services case management programs.

/2005/ See Chart #11 Trends in Asthma Hospitalization Rates by Age Group attached to Section I.D. Table of Contents. //2005//

#2 HSCI - The percent Medicaid enrollees whose age is < 1 year who received at least one initial periodic screen.

Medicaid in New Jersey is administered by the Division of Medical Assistance and Health Services (DMAHS) in the New Jersey Department of Human Services. DMAHS and DHSS have collaborated on the development of educational materials on the importance of preventive health services for young children, with an emphasis on the services included in EPSDT. DMAHS has been distributing these materials to the parents of children enrolled in Medicaid.

One of the major focuses of the Prevention Oriented Services for Child Health (POrSCHe) initiative is to promote proper use of preventive health services by the families of children at high risk of preventable health and developmental problems. POrSCHe nurse case managers work with the parents of these children to encourage their enrollment in Medicaid or New Jersey FamilyCare (if eligible), and the use of preventive and primary care pediatric services, particularly immunization and lead screening. There are POrSCHe projects in 11 communities.

#03 HSCI - The % State Childrens Health Insurance Program (SCHIP) enrollees whose age is < 1 year who received at least one periodic screen.

New Jersey FamilyCare is New Jersey's SCHIP. It is administered by the Division of Medical Assistance and Health Services (DMAHS) in the New Jersey Department of Human Services. DMAHS and DHSS have collaborated on the development of educational materials on the importance

of preventive health services for young children, with an emphasis on the services included in EPSDT. DMAHS has been distributing these materials to the parents of children enrolled in NJ FamilyCare.

One of the major focuses of the Prevention Oriented Services for Child Health (POrSCHe) initiative is to promote proper use of preventive health services by the families of children at high risk of preventable health and developmental problems. POrSCHe nurse case managers work with the parents of these children to encourage their enrollment in Medicaid or New Jersey FamilyCare (if eligible), and the use of preventive and primary care pediatric services, particularly immunization and lead screening. There are POrSCHe projects in 11 communities.

#04 HSCI - The % of women (15 - 44) with a live birth whose observed to expected prenatal visits are >= 80 % on the Kotelchuck Index.

The Healthy Mothers, Healthy Babies (HM/HB) Coalitions promote early prenatal care utilization through outreach and education. Outreach efforts include door-to-door canvassing of neighborhoods, presentations at community events and the availability of outreach workers where pregnant women may gather such as food stores, hair and nail salons and laundromats. Outreach workers have been trained to educate pregnant women on the importance of early prenatal care and to connect them to prenatal care services. Educational efforts include formal presentations to community groups, organizations and faith based initiatives on the importance of early prenatal care. Education is also provided to health care providers to eliminate barriers to early prenatal care including cultural sensitivity, the need for multi-lingual multi-cultural staff and the need for family friendly office space and scheduling.

#05 HSCI - Comparison of health indicators for Medicaid, non-Medicaid, and all populations in the State

The BIMR, HM/HB, FIMR, FAS, Perinatal Addictions and HealthStart initiatives are designed to improve birth outcomes for all women through the identification of factors related to LBW, infant mortality and prenatal care and the development of programs to address these factors. The BIMR project is designed to reduce black infant mortality (SP #3) through public awareness and community education campaigns. HM/HB Coalitions (NPM #18) are designed to improve birth outcomes through extensive community outreach and education activities based on Community Action Team projects based on FIMR (NPM #17) results. The FAS and Perinatal Addictions projects (SP #9) educate providers and consumers on the effects of substance abuse on LBW, infant mortality and prenatal care. The HealthStart initiative provides comprehensive health services and maternity and newborn services for high-risk women and infants (NPM #15).

#06 HSCI - The % of poverty level for eligibility in the State's Medicaid and SCHIP programs for infants, children, and pregnant women.

The Medicaid Program in New Jersey is located in the Department of Human Services. Pregnant women with incomes below 185% of the Federal Poverty Level are eligible for Medicaid Health Start comprehensive maternity services. The comprehensive services include medical care, case coordination, health education and psychological services.

#07 HSCI - The % of EPSDT eligible children aged 6 - 9 years who have received any dental services during the year.

Based upon FFY 2002 data, a total of 29,448 (27%) eligible 6 - 9 year old children received dental services during FFY 2002 out of 107,017 children eligible for EPSDT services. Dental initiatives undertaken to promote utilization of dental services are:
-MD Education Regarding Dental Referrals - EPSDT Screenings: A letter was sent to all Medicaid/NJ FamilyCare Primary Care Physicians (General Practice, Family Practice, Internal Medicine, Pediatricians) and Nurse Practitioners (Family, Pediatrics, Community Health, School Health)

enlisting their help in the eradication of childhood dental disease by performing a dental inspection during the EPSDT physical examination and making referrals to a dentist within the timeframes recommended by the Medicaid/NJ FamilyCare program or whenever dental disease is identified.
-Oral Health Stuffer: A stuffer, aimed at increasing utilization of dental services by educating beneficiaries and/or parent/caretakers about the importance of good oral health and the relationship to good overall health, was developed and distributed to Medicaid/NJ FamilyCare families.
-Quarterly Dental Director's Meetings: Office of Quality Assurance conducts quarterly meetings with the HMO dental directors to discuss quality issues including EPSDT.
-Annual Report of EPSDT Performance Measures: The Office of Quality Assurance contracts with the Peer Review Organization of New Jersey to conduct an annual study of HMO EPSDT performance.
-HMO Annual Assessment: DMAHS conducts annual assessments of HMO performance which includes questions in the dental element regarding measures taken to improve utilization of dental services for EPSDT eligibles.

#08 HSCI - The % of State SSI beneficiaries < 16 receiving rehabilitation services from the State CSHCN Program.

SCAEIS continues to ensure that Supplemental Security Income (SSI) beneficiaries less than 16 years old received rehabilitation services. Although SCAEIS does not provide direct rehabilitative services to SSI beneficiaries, the program does provide the outreach and case management services to ensure that SSI beneficiaries receive these necessary services. In New Jersey, SSI beneficiaries who meet family income guidelines are eligible for comprehensive Medicaid benefits, which include the rehabilitative services of audiology, physical, occupational, and speech therapy. All New Jersey children applying for SSI disability are referred by the State SCAEIS office to the County Case Management Units through a letter of agreement with New Jersey Department of Labor, Disability Determinations.
/2005/ In 2003,approximately 3,000 SSI beneficiaries less than 16 years old will have had an Individual Service Plan including rehabilitative services developed for them by the County Case Management Units. Approximately 25% of the children in active case management case load are SSI recipients. In an effort to improve outreach to SSI beneficiaries, the Department has modified the database forwarded by Disability Determinations to access beneficiary's telephone numbers. It is anticipated that this additional information will improve outreach efforts and result in an increase in SSI beneficiaries served.//2005//

#09A HSCI - The ability of States to assure Maternal and Child Health to policy and program relevant data/information.

The goals of the State Systems Development Initiative (SSDI) grant within the MCH Epidemiology Program focus on Health Status Indicator (CHSI) #9A for building data capacity in MCH. The first goal of the grant focuses on improving linkages of MCH datasets and the second goal of the grant focuses on improving access to MCH related information. Linking MCH related datasets is important to the needs assessment process for communities and the evaluation of program services. Assuring access of FHS to MCH related datasets is important to improving the reporting of Title V MCH Block Grant Performance/Outcome Measures and to improving the delivery of services to the MCH population.

Our vital statistics files, Medicaid files and programmatic data files all provide some information about the status of health in the MCH population and the effectiveness of MCH programs. However, no file alone provides the full picture of what happens to pregnant women, infants and children. In order to accurately assess the continuum of events that lead to favorable or unfavorable outcomes, files and information systems should be linked.

MCH Epi has been able to both link records across files and longitudinally across health care related events in a mother's life. A combined dataset was created for the years 1996 through 2002 containing the electronic birth certificate, mother and newborn hospital discharge records, and infant death certificates for all NJ births. Data from this dataset are used to support research projects that focus on welfare reform and immigrant health, foreign-born mothers and issues related to health disparities,

and maternal mortality review in New Jersey.

Six years of asthma-related hospital discharge data have been longitudinally linked to create a wealth of information surrounding hospitalizations for children with asthma. This dataset is being used to enhance our asthma surveillance system as well as examine issues related to repeat admissions, and asthma severity.

The MCH Epidemiology Program with CDC funding has also implemented the Pregnancy Risk Assessment Monitoring System (PRAMS) Survey in collaboration with the Center for Public Health Interest Polling at Rutgers University. Additional funding was obtained from the Division of Additions within the NJDHSS to include questions concerning maternal smoking. Data from this survey will be used to identify pregnancy risks and to develop international and programmatic interventions.

#09B HSCI - The ability of States to determine the percent of adolescents in grades 9 - 12 who report using tobacco products in the past month.

The New Jersey Youth Tobacco Survey (YTS), based on a model developed by CDC, is administered by the DHSS Division of Addiction Services. 2003 will be the third year that New Jersey will have done a YTS. This bi-annual survey is administered to a sample of students in grades seven through twelve. The 2001 YTS report is available at www.state.nj.us/health/as/yts/. Current cigarette smoking prevalence among high school students fell from 27.6% in 1999 to 24.5% in 2001, an 11% decline. The YRBS also collects information on adolescent smoking, but is not as focused and extensive on tobacco use as the YTS.

#09C HSCI - The ability of States to determine the percent of children who are obese or overweight.

The Youth Risk Factor Behavior Survey (YRBS) includes the collection of data on height and weight. The YRBS is administered by the New Jersey Department of Education (DOE) with significant assistance from the DHSS. The YRBS survey results for New Jersey high school students from 2001 show one in ten students were overweight (>= 95th percentile for Body Mass Index (BMI) by age and sex). However, another 14.6% of high school students were found to be "at risk" for overweight (85th to 95th percentile BMI).

A working group from DHSS, DOE, and the Department of Law and Public Safety met to address newly required active parental consent for students to participate in surveys at school and concerns about adequate return rates for the YRBS and other school surveys. They developed a New Jersey School Survey (NJSS) for administration in 2003, which includes the height and weight elements of the YRBS. The NJSS combines core elements of the YRBS, Youth Tobacco Survey, and the Attorney General's survey on drug use. A middle school version of the NJSS is currently in development. ***/2005/ A random survey of sixth graders is being conducted to compile height and weight data to establish baseline information concerning overweight and obesity prevalence of NJ youth.//2005//***

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

The Government Performance and Results Act (GPRA - Public Law 103-62) requires that each Federal agency establish performance measures that can be reported as part of the budgetary process that links funding decisions with performance and related outcome measures to see if there were improved outcomes for target populations.

Since 1999 Maternal Child Health Bureau (MCHB) has included performance plans and performance information in its budget submission. MCHB must submit annual reports to Congress on the actual performance achieved compared to that proposed in the performance plan. This section describes the performance reporting requirements of the Federal-State partnership. Figure 3, "Title V Block Grant Performance Measurement System" on the next page, presents a schematic of a system approach that begins with the needs assessment and identification of priorities and culminates in improved outcomes for the Title V population. After each State establishes a set of priority needs from the five-year Statewide needs assessment, programs are designed, assigned resources, and implemented to specifically address these priorities. Specific program activities are described and categorized by the four service levels found in the MCH "pyramid" ? direct health care, enabling, population-based, and infrastructure building services. Program activities, as measured by 18 National performance measures and State performance measures should have a collective contributory effect to positively impact a set of 6 national outcome measures for the Title V population.

B. STATE PRIORITIES

SP #1. Reduction of Adolescent Risk Taking Behaviors

The Reduction of Adolescent Risk Taking Behaviors relates to National Performance Measures #8, 10, 13, 16 and State Performance Measures #5, 6 and 10. DHSS funds Community Partnerships for Healthy Adolescents in eight communities. The purpose of these Partnerships is to coordinate the work of local health departments, community-based organizations and health care providers in reducing risk-taking behaviors and promoting healthy behaviors among adolescents. Each Partnership's activities are based on a local needs assessment that identified what are the priority adolescent health issues in that community. It then develops an Adolescent Health Plan to address these issues. DHSS guidelines encourage the Partnerships to address sexual behaviors, injury prevention, and nutrition and physical activity.
/2005/ DHSS funds Community Partnerships for Healthy Adolescents in eight communities.

SP #2. Reducing Black Infant Mortality

Reducing Black Infant Mortality is a state priority related to National Performance Measures #15, 17 and 18 and State Performance Measures #1 and 3. During the reporting period there has been significant activity to address Outcome Measure # 2, reducing black infant mortality, and State Performance Measure #1, reduction of the percent of black preterm births. The Black Infant Mortality Reduction Advisory Council has assisted the Department in several new and exciting initiatives. The public awareness campaign Black Infants Better Survival (BIBS) was the culmination of a concerted effort on the part of the Department in response to recommendations of the Blue Ribbon Panel Report and the Advisory Councils priority interests. The campaign was unveiled in May 1999, and ran for two years. The public awareness and community education components of the campaign were targeted to get information out to black women of childbearing age and their families concerning the increased risk and strategies to improve pregnancy outcomes. A third component, professional education, targets health care providers to increase awareness, provide current data, dispel myths, suggest strategies for intervention, and discuss the impact of cultural competency on black infant mortality. The campaign currently uses the Family Health Line. The link to the Family Health Line ensures easy access to local resources for callers.

The Northern New Jersey MCH Consortium has been funded to serve as the Black Infant Mortality Reduction (BIMR) Resource Center under the Black Infant Mortality Reduction Initiative since July 1999. The Center is designed to provide technical support to programs and information to professionals with an interest in improving maternal and infant health in black families. The Center also serves as a collection and distribution site, which facilitates review of existing publications and ongoing research efforts. It acts as a clearinghouse, providing literature, statistics, and other information on black infant mortality. The Center advocates for policies and programs that address the issue of racial disparity in infant death.

As a fourth component, seven health service grants addressing black infant mortality reduction, totaling one million dollars were awarded in June 2000 to health service agencies and grassroot organizations statewide. The agencies that were awarded these grants and the activities they are performing are described as follows.

Ad House, previously funded through A Healthy Start for Essex County grant, is providing an expansion of Healthy Start outreach services. The goal is to reach an additional 50 adolescents and women of childbearing age, at the Family Resource Center. Services at the Family Resource Center include health education, comprehensive prenatal care, case coordination, and linkages/referral for other services, babysitting and transportation.

The Central New Jersey Maternal and Child Health Consortium, targeting New Brunswick, Plainfield and surrounding areas, was funded to provide increased prenatal case finding, public health nursing visitation, linkage, and referral. Prevention education addresses preconceptional, prenatal, and postpartum health care. There is an additional focus of community education to increase community awareness about the issues of black infant mortality and risk reduction. A strong component of the BIMR initiative is the comprehensive home visitation services provided by nurses in New Brunswick and Plainfield. Through these services, nurses visit African American women, on a bi-monthly basis to provide stress reduction education, assess specific needs of women, and to ensure access to regular and adequate prenatal care. To date, the program has served 16 women, as well as, connected or reconnected 46 additional women to prenatal care.

The Central NJ Partnership on BIMR has also established a network of faith-based organizations and healthcare providers working to increase awareness about the issue of BIMR. On February 5, 2003, 260 church members attended an awareness dinner titled "Lessons in Living: Celebrating Health, Spirituality, and Community".

The East Orange Department of Health, Infants, Mothers, and Families Division, provides prenatal case finding through community outreach. Case management and mentoring services for clients are provided by the public health nursing division and trained volunteers. Public awareness activities to increase community knowledge about black infant mortality have been implemented. East Orange Health Department has developed successful public-private partnerships.

The Heureka Center, Burlington County, provides community outreach and mentoring services. Community health education targets prenatal and pediatric populations in Burlington County. Case management, risk prevention and reduction activities will seek to improve access and quality of care.

The Hudson Perinatal Consortium provides risk and stress reduction, positive prenatal practices and parenting skills during the provision of prenatal services throughout Hudson County. Clients are recruited through intensive prenatal community outreach and canvassing with case coordination for health and social service needs.

The Northern New Jersey Maternal and Child Health Consortium, provides individual and group stress reduction counseling to prenatal women as an intervention in reducing the

incidence of preterm labor and low birth weight births. Case coordination and referrals will be provided for clients as needed. To date, 79 women have enrolled in this project. Of the 29 women who have completed the stress reduction program, 23 have delivered normal birth weight babies.

The City of Trenton, Division of Health, provides extensive community outreach, canvassing and interagency case coordination, with volunteer client mentoring services. These services are expansion of peer mentoring services provided by partnering agencies. Currently, 45 women are receiving weekly home visits from a mentor. Monthly dinner meetings are held with current and past participants with a health, social service or parenting topic presented.

SP#3. Reducing Teen Pregnancy

Teen pregnancy prevention is a state priority for New Jersey and relates to National Performance Measures #8 (reduction of births to teens 15-17 years of age) and State Performance Measures #4 (percent of repeat pregnancies among adolescents 15-19 years of age). Several inter-agency initiatives have been developed to address this priority.

The Advisory Council on Adolescent Pregnancy Prevention was established in April 1999 to develop policy proposals, to promote a coordinated and comprehensive approach to the problems of adolescent pregnancy and parenting, and to promote community input and communication. In 2003, the Council developed a three-year strategic plan to guide the work of the Council and focus on specific areas of interest. The WorkFirst Teen Pregnancy Prevention Work Group lead by the Department of Human Services has been charged with planning, developing and implementing new initiatives. Youth-to-youth programs and mentoring projects and a Teen Pregnancy Resource Center has been established.

The Department of Human Services, the Department of Education, the Department of Labor and the Juvenile Justice Commission have collaborate with NJDHSS on the development of statewide County Collaborative Coalitions relative to teen pregnancy prevention activities. Regional forums continue to be held which bring together stakeholders from a variety of agencies and organizations to envision, plan and implement local adolescent pregnancy prevention activities and events for Teen Pregnancy Prevention Month (May).

Family planning agencies with 60 clinical sites continue to provide comprehensive reproductive health services to adolescents. Family planning agencies also provided community education and outreach to the adolescent population. Aimed at schools and community groups, educational activities focus on primary pregnancy prevention activities that encourage family communication, promoting self-esteem, postponing sexual activity and promoting effective contraception. The program integrates assessment of adolescent risk behavior within routine family planning services.

The percent of repeat births among adolescents 15-19 years of age (State Performance Measure # 5) is a priority because teen parents are more likely to have another child within two years, often leading to increased hardship and economic dependency. A demonstration parenting project, in Bridgeton, serving Cumberland County, continues to use home visiting to promote the physical and psychosocial health of low-income childbearing adolescents and their infants. The program supports their goals to complete high school or GED requirements, linking them to primary care providers, ensuring that both the teen and infant receive preventive and primary health care, and preventing unintended pregnancies.

SP#4. Increasing Healthy Births

Increasing Healthy Births is a state priority that encompasses National Performance Measures #8, 15, 17, 18 and State Performance Measures #1, 3, 5, 8, 9. Several initiatives in the Perinatal Health Services Program address healthy births including Healthy Mothers, Healthy Babies

Coalition outreach activities, Healthy Start outreach activities, and Community action team projects based on FIMR findings. The Perinatal Addictions projects seek to educate professionals and consumers of the risks involved with substance use and abuse in the perinatal period. Preconceptual health projects seek to have a healthy mother prior to conception.

SP#5. Improving Nutrition and Physical Fitness

Improving Nutrition and Physical Fitness is a state priority related to State Performance Measures # 10 and the New Health System Capacity Indicator #9. DHSS funds Community Partnerships for Healthy Adolescents in eight communities. The purpose of these Partnerships is to coordinate the work of local health departments, community-based organizations and health care providers in reducing risk-taking behaviors and promoting healthy behaviors among adolescents. DHSS staff work with the Partnerships to address nutrition and physical activity as priority adolescent health issues. State law has established a New Jersey Council on Fitness and Sports. DHSS provides staff support to the Council.
/2005/ DHSS has provided funding to two statewide organizations - the New Jersey Society of Public Health Education and the New Jersey Association for Health, Physical Education, Recreation and Dance - to support pilot projects implementing recommendations of the Council. It is also funding a community-based organization in Trenton to support fitness promotion initiatives for the community. Currently DHSS funds Community Partnerships for Healthy Adolescents in eight communities.//2005//

SP#6. Decrease Hospitalizations Asthma

Decrease hospitalizations asthma is related to National Performance Measures #7, 13 and State Performance Measures #6 and 14. DHSS is a member of the Pediatric Asthma Coalition of New Jersey (PAC/NJ). PAC/NJ is organized by the American Lung Association of New Jersey and the New Jersey Thoracic Society. It has developed a Strategic Plan to address asthma in New Jersey, and has formed six task forces to develop and implement activities to achieve the objectives of the Plan.
/2005/ Significant accomplishments to date include the development of a model Asthma Action Plan form, a single-page summary for physicians of the NHLBI Guidelines for asthma care, training program and video for school nurses and classroom staff, and a public information sheet on the "Top Ten Things You Can Do to Reduce Asthma Triggers in the Home." DHHS staff participate on the Steering Committee of the Coalition, as well as on the School, Child Care, Education, and Health Insurance task forces.//2005//

In 2002, the DHSS formed an Interdepartmental Working Group on Asthma. With the participation of staff from the Departments of Education, Human Services, and Environmental Protection, the working group prepared a strategic plan for the activities of New Jersey State Government in addressing asthma.

The New Jersey Special Child Health Services Registry allows for the voluntary reporting of asthma as a chronic condition in children. Children registered are referred to the Family Centered Care Program, which provides case management assistance to the families through the county-based Special Child Health Services case management programs.

SP#7. Improving and Integrating Information Systems

The MCH Epidemiology Program, the Division of Family Health Services, and the NJDHSS are all involved in efforts to improve and integrate public health information systems. Activities are related to National Performance Measures #1, 9, 12 and Health System Capacity Indicator #5, 9A, 9B, and 9C. Examples of improving access to and integration of public health information are discussed in sections specific to the performance measures and health systems capacity indicators.

SP#8. Improving Access to Quality Care for CSHCN

/2005/ New Jersey will continue to enhance current efforts to improve access to quality of care for CSHCN, as well as provide additional training opportunities for families, case managers, Part C service coordinators and staff of the Child Evaluation Centers, Cleft Lip/Palate Centers, Tertiary Care Centers, and Ryan White Title IV Family Centered HIV grantees in resources and services to support CSHCN in the community. Training will be provided to promote effective involvement of youth and parents in school to work transition, and medical transition to adulthood for the SSI population.

/2005/ Information, referral, development of an individualized service plan (ISP) and ongoing monitoring to achieve identified needs for CSHCN remains a priority of Family Centered Care grantees. These needs include medical/dental, developmental, rehabilitation, education, socio-economic, and emotional. Parent and professional training on accessing comprehensive services for CSHCN through Medicaid Managed Care was conducted in 2003, through quarterly case management meetings, and Family Centered HIV programs, Likewise, Family Centered Care Services staff provide ongoing technical assistance to grantees regarding access to care issues, including how to access appropriate community based providers, and how to coordinate services across intergovernmental agencies and programs. This state priority is related to NPM #1-6, 12, 13, 14, SPM #6, 7, 8 and HSCI #1 and 8. //2005//

C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

a. Last Year's Accomplishments

The Newborn Biochemical Screening Follow-up Program, located within Special Child, and Adult Services and Early Intervention Services (SCAEIS) ensures that babies with abnormal results from screening receive timely confirmatory testing, follow-up care and management. The goal is to arrange for confirmation, initiation of diagnosis, and treatment within nationally established time lines as applicable.

Prior to October 2003, screenings were provided for fourteen disorders; currently, newborns receive screening for twenty disorders: phenyketonuria, hypothyroidism, galatosemia, the hemoglobinopathies, including sickle cell disease, maple syrup urine disease, cystic fibrosis, biotinidase deficiency, congenital adrenal hyperplasia, medium chain acyl-CoA dehydrogenase deficiency, short chain acyl-CoA dehydrogenase deficiency, long chain acyl-CoA dehydrogenase deficiency, very long chain acyl-CoA dehydrogenase deficiency, citrullinemia, argininosuccinic academia, methylmaloonic acidemia, propionic acidemia, glutaric acidemia Type I, isovaleric acidemia, 3-hydroxy-3-methylglutaryl CoA lyase deficiency and 3-methylcrotonyl-CoA carboxylase deficiency. In the past 1 1/2 years, support for treatment services and formula has also significantly expanded to include three regional metabolic centers, 3 cystic fibrosis care centers, 5 pediatric endocrine specialty care centers, 2 biochemical genetics laboratories and 5 sickle cell treatment centers.

b. Current Activities

Currently, newborns are screened for twenty disorders listed above. In 2002, SCAEIS began funding for the establishment and provision of specialty services in the areas of genetics/metabolic disorders, pediatric pulmonary and endocrine disorders, and specialty laboratory services. Needs for these services are due to the increase in numbers of children being identified with biochemical disorders through newborn screening.

c. Plan for the Coming Year

Testing, reporting and follow-up for the additional screening tests will continue to be directly managed by the State and available statewide. As genetic tests are perfected, it will be possible to screen for more newborn biochemical disorders. Since there are no national standards concerning which disorders to include in a screening panel, states are faced with balancing the new technologies into the system of newborn screening. More than just laboratory tests, the system must be able to follow, treat, and influence clinical outcomes. To address these changes and concerns, a Newborn Screening Annual Review Committee will be reconvened and will serve to advise the Newborn Biochemical Screening Program.

For each of the newborn biochemical disorders, quarterly meetings are held with the respective consultant groups. These groups are comprised of a wide range of medical specialists and other health care providers involved in the diagnosis and management of the disorders. The purpose of the consultant meeting is to ensure that testing and follow-up procedures used by the State are reflective of best medical and laboratory practices. Additionally, the medical consultants represent the concerns of families with affected newborns, including such diverse issues as insurance reimbursement, obtaining referrals for appropriate pediatric consultants, and identification of other unmet needs.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

a. Last Year's Accomplishments

SCAEIS continues to support through a health service grant with the Statewide Parents Advocacy Network (SPAN) the a Parent-to-Parent Network to further increase the degree to which the State ensures family participation in program and policy activities of the State CSHCN program. The Parent-to-Parent Network links parents of CSHCN to "veteran" parents of children with similar needs for support, information on the disability, and problem solving.

b. Current Activities

The training and matching of parents through the Parent-to-Parent Network continues during the current year. To date, 475 support parents have been trained and nearly 600 matches have been made.

c. Plan for the Coming Year

Projections for FFY 2005 estimate an additional 120 parents will be trained and 180 matches made. The Statewide Family Voices Chapter, initiated by SCAEIS in collaboration with Family Voices and SPAN, will continue conducting family leadership development trainings. These trainings provide families with the information and support they need to advocate for their own children, advocate for and support other families, and advocate for improvements in policies, practices, and systems.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

a. Last Year's Accomplishments

SCAEIS continues to provide enabling services to children with special health care needs (CSHCN) in order to ensure a "medical/health home" (National Performance Measure #3). SCAEIS has promoted the concept of a "medical home" as defined by the American Academy

of Pediatrics through case management services, collaboration with the Statewide Parent Advocacy Network (SPAN), and support of the Child and Adult Special Services Program providers. SCAEIS participated in the "Your Voice Counts" study beginning in August 1998, a collaborative effort between Family Voices, Brandeis University, and Title V agencies. Two hundred families involved in case management were surveyed to learn about their experiences with health insurance, managed health care, and the health system. The survey included questions regarding status of primary care provider, coordination of care, access to specialists and therapists, and other health issues. Preliminary results indicated that 89% of respondents reported that their child had a primary care provider. The majority reported having a case manager, either through their primary health insurance plan, MCH program, State Developmental Disabilities program, or other affiliation, and that the case manager was of assistance in coordinating care. In 2002, SCAEIS State staff conducted a statewide review of Individual Service Plans for children receiving Special Child Health Services case management to determine status of insurance and whether a primary care physician was identified. Of the 100 charts sampled, 92% documented a form of health coverage (approximately 50% Medicaid and 50% private), and 94% identified a primary care provider. Those without insurance had been screened for eligibility and/or referred for SSI, NJ Kidcare, and/or Medicaid. Also, children without a documented primary care provider had been referred for follow-up through Federally Qualified Health Centers, local health department and/or hospital clinics, as well as referral to pediatricians that may be accepting clients without insurance. This informal survey indicated that the majority of children served through the Case Management Units have access to both health care and a primary care provider; however, access to a medical home remains a challenge for some children. This survey will be repeated in 2004, and extended to include additional Family Centered Care Services providers.

b. Current Activities

To assist families in accessing the Medicaid managed care system, SCAEIS County Case Managers continue to provide consultation, advocacy, information and referral to access comprehensive health care coverage. In an effort to assist families of children with special needs in navigating the Medicaid managed care system, a Medicaid Managed Care Alliance was formed in October 1999. This Alliance is comprised of parents, advocacy groups, representatives from the DHS Office of Managed Care, NJ FamilyCare, HMO case managers, SCAEIS case managers and others. A brochure entitled "Finding Your Way through Medicaid Managed Care?For Families with Children with Special Needs," was developed through this initiative, and continues to be distributed statewide. In 2003, resources listing both managed care case managers and county case management unit staff were revised and distributed among staff members of both systems. Periodic case conferencing continues as needed. In the Pediatric HIV Family Centered Care Network, each of the Network agencies has entered into linkage agreements with the managed care systems operating within their catchment areas. These agreements will ensure the delivery of coordinated primary and specialty care for the HIV affected special needs children and their families.

SCAEIS continues to provide or subsidize direct specialty and subspecialty services to CSHCN by funding Child and Adult Special Services which includes: eleven Child Evaluation Centers, five Cleft Palate Centers, three Tertiary Centers, six Genetic Centers, four Hemophilia Centers and five Sickle Cell Centers. These centers provide a comprehensive array of services with a multidisciplinary approach to assure that CSHCN receive coordinated, ongoing, comprehensive care within a medical home. Services are provided to the uninsured and underinsured utilizing a sliding-fee-scale and include a comprehensive array of services consistent with the multidisciplinary team approach to advocate for CSHCN. Approximately 42,080 children received services within the specialty network for the first time during 2003. Additionally, a special insurance program is available for those individuals with Hemophilia A or B who do not have access to any of the traditional insurance programs. The Sickle Cell and Hemophilia programs currently focus on implementing transition activities as pediatric aged patients

approach adolescence and adulthood.

c. Plan for the Coming Year

To assist families in accessing the Medicaid managed care system, SCAEIS County Case Managers will continue to provide consultation, advocacy, information and referral to access comprehensive health care coverage. Approximately 11,000 children are newly referred to the Special Child Health Services (SCHS) County Case Management Units each year, and all are offered case management/care coordination including the development of Individual Service Plans (ISP) that address assessment of and need for comprehensive health, education, social, and rehabilitative services. Included in the ISPs are enabling services such as transportation, economic assistance, service linkages, respite care, and general support in terms of rights and safeguards. Case managers work with these families and their physicians to ensure care that is accessible, continuous, comprehensive, family-centered, coordinated, and compassionate.

In the Pediatric HIV Family Centered Care Network, each of the Network agencies has linkage agreements with the managed care systems operating within their catchment areas. These agreements will ensure the delivery of coordinated primary and specialty care for the HIV affected special needs children and their families.

SCAEIS will continue to provide or subsidize direct specialty and subspecialty services to CSHCN by funding Child and Adult Special Services which includes: eleven Child Evaluation Centers, five Cleft Palate Centers, three Tertiary Centers, six Genetic Centers, four Hemophilia Centers and five Sickle Cell Centers. Services will be provided to the uninsured and underinsured utilizing a sliding-fee-scale and include a comprehensive array of services consistent with the multidisciplinary team approach to advocate for CSHCN.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

a. Last Year's Accomplishments

SCAEIS has greatly improved the accessibility of Children with Special Health Care Needs (CSHCN) to primary and specialty care through the support of specialized pediatric services and County Case Management Units. Health insurance data extrapolated from the combined CSHCN programs estimate that 3.5% of the 42,080 CSHCN children served in 2003 were reported uninsured on the SCAEIS sliding fee scale. This can be compared with 6.0% uninsured in 1999. With the advent of FamilyCare to expand health insurance coverage, the percentage of uninsured CSHCN is anticipated to further decrease. Improvements in the reporting of insurance type are expected to reduce the percentage of unknowns. The County Case Management Units will continue to provide care coordination at no expense to families and to assist in referring families to resources such as Medicaid, New Jersey FamilyCare, the Catastrophic Illness in Children Relief Fund program, and the Charity Care program.

b. Current Activities

Despite challenges created by a rapidly changing health care environment, SCAEIS has continued to ensure the availability of specialty and subspecialty services, including care coordination, not otherwise accessible to children with special health care needs (CSHCN). The CSHCN programs in New Jersey have traditionally provided and/or financed specialty and subspecialty care services through a network of specialty clinics. More emphasis continues to be placed on providing care coordination through the County Case Management Units. With many families transitioning to managed care, the care coordination services of County Case

Management Units are now even more important to ensure comprehensive care due to potential restrictions created by utilization review, referral requirements, and closed panel networks. Anecdotal experience this past year has proven the benefits of the County Case Management Units who have assisted families in navigating the complicated managed care system to obtain necessary services.

c. Plan for the Coming Year

SCAEIS will continue to ensure the availability of specialty and subspecialty services, including care coordination, not otherwise accessible to children with special health care needs (CSHCN). With transition of children served by the Department of Human Services, Division of Youth and Family Services, into Medicaid Managed Care targeted for enrollment in 2004, SCAEIS will continue to collaborate with other Medicaid Managed Care Alliance members to enhance existing access to specialty and subspecialty services. The County Case Management Units will continue to provide care coordination at no expense to families and to assist in referring families to resources such as Medicaid, New Jersey FamilyCare, the Catastrophic Illness in Children Relief Fund program, and the Charity Care program.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

a. Last Year's Accomplishments

In 2003, SCAEIS, and the Statewide Parent Advocacy Network (SPAN), continued collaborative efforts to ensure access to care for CSHCN. Family input is on services through participation at Family Centered Care Services provider meetings, both as attendees and presenters; including transition, advocacy and support.

b. Current Activities

Collaboration between the Statewide Parent Advocacy Network (SPAN) and SCAEIS, which began ten years ago, has enhanced the provision of accessible family-centered care. SPAN is the only federally funded parent training and information center for parents of children with disabilities and special health care needs in New Jersey. During 2003, eleven Case Management Units housed 14 SPAN Resource Parents who provided technical assistance and support to families and/or staff in the areas of specific disabilities and education, as well as transition to preschool and adulthood issues through Project Care. The Resource Parents documented nearly 6,600 contacts with families and professionals during that time. In addition, SCAEIS provided funding in 2002 for a project enabling volunteer parents trained through SPAN to provide statewide coverage for the New Jersey Parent-to-Parent Program. As another statewide initiative, SCAEIS continues to collaborate and partially support a Family Voices chapter, whose mission is to provide parents with training in family leadership, policy making, and advocacy in health care.

c. Plan for the Coming Year

Collaboration between the SPAN and SCAEIS, will continue to enhance the provision of accessible family-centered care. SPAN Resource Parents will provide technical assistance and support to families and/or staff in the areas of specific disabilities and education, as well as transition to preschool and adulthood issues through Project Care. SCAEIS will continue to collaborate and partially support a Family Voices chapter.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

a. Last Year's Accomplishments

In addition to ongoing transition to adulthood information, referral, counseling and support provided by Family Centered Care grantee's case managers, SPAN Resource Specialists, social work and medical staff, multiple transition trainings were conducted in 2003, through parent and provider organization collaborations. As members of the ARC of New Jersey's Mainstreaming Medical Care Executive Committee, Family Centered Care staff assisted in developing and conducting a training for parents of CSHCN at the ARC of New Jersey's 14th Annual Mainstreaming Medical Care Conference. Panel presenters included an adolescent with chronic medical needs, a pediatric orthopedic surgeon, and a New Jersey Medicaid representative discussing challenges and solutions to planning effective transition. Likewise, parent and professional training was provided through collaboration with the NJ SSI Alliance, an association of SSI stakeholders including consumers, State agencies, and advocacy groups. Approximately 200 attendees participated in the 5th Annual NJ SSI Alliance Conference. Targeting SSI beneficiaries, the 2003 conference included topics such as how to access SSI benefits, medical and educational transition to adulthood, Ticket to Work, PASS, and NJ Workability.

b. Current Activities

Enabling transition to adulthood for CSHCN is approached through several ongoing collaborative efforts between Family Centered Care Services staff, intergovernmental agencies, and parent advocacy groups. Since 1993, Family Centered Care Services staff collaborated with staff from the Social Security Administration, New Jersey Epilepsy Foundation, Department of Labor Vocational Rehabilitation and Disability Determination units, Department of Human Services Medicaid and Mental Health units, advocacy groups such as SPAN, Community Health Law Project, Family Voices New Jersey, Legal Services of New Jersey and others, on the development of the New Jersey SSI Alliance. The SSI Alliance meets quarterly to share information, promote awareness and provide training and technical assistance related to SSI benefits and supports, which are invaluable to youth transitioning to adulthood.

In addition, a draft transition to adulthood packet has been developed through a pilot project conducted in collaboration with SPAN and the Essex Healthcare Foundation, at the Essex County SCHS case management unit. The packet targets families with CSHCN and includes information on Department of Education Section 504 basic rights, Individual Health Plan development, SPAN, SCHS, and a description of the New Jersey Catastrophic Illness in Children Relief Fund financial assistance program. Preliminary plans for distribution of the packet to CSHCN age 13 and older served through the county case management units are underway. Likewise, during 2003, a statewide training about transition to adulthood was conducted by SPAN for parents of CSHCN, and staff of the SCHS Case Management Units, Child Evaluation Centers, Cleft Lip/Palate Centers, Tertiary Centers, Family Centered HIV Centers, and HMO case managers.

c. Plan for the Coming Year

The SSI Alliance will continue to meet quarterly to share information, promote awareness and provide training and technical assistance related to SSI benefits and support, which are invaluable to youth transitioning to adulthood. The fifth annual SSI Alliance Conference will again target SSI enrollees and professionals, and is scheduled for fall 2004.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

a. Last Year's Accomplishments

New Jersey has achieved a 76% age appropriate immunization rate in 2002, according to the CDC National Immunization Program. To address age appropriate immunizations (National Performance Measure #7), the Immunization Program in the Division of Communicable Diseases continues to support immunization at clinics in local health departments, Federally Qualified Health Centers (FQHCs), and other pediatric clinics. The State's Vaccines for Children Program became available to private practitioners for the first time in 1999. The Division of Family Health Services (FHS) continues to work collaboratively with the Immunization Program to promote age appropriate immunizations.

b. Current Activities

The New Jersey Department of Health and Senior Services will begin the "rolling-out" of a re-designed, web based, statewide universal childhood Immunization Registry in April 2003, through a series of introductory efforts sponsored by the seven regional maternal child health consortia. All newborn infants in New Jersey are automatically entered into the system at birth via the Electronic Birth Certificate. Interfaces with private insurance carriers have been completed and they will be able to populate the registry as well via physicians accounting entries once the enabling legislation completes its way through the State Legislature. A new, nationally sponsored program, NICHQ, has been joined by DHSS and the New Jersey Chapter of the American Academy of Pediatrics to facilitate the introduction of the Immunization Registry into practice sites in targeted areas of particular need. Similar efforts are on-going with the Academy of Family Practice of New Jersey as well. The Registry interfaces with the programmatic requirements of WIC and Medicaid.

In 2003 the Perinatal Health Services Program was charged with the responsibility of integrating immunization with the Maternal and Child Health Consortia (MCHC). To this end, Reza Behbehanian, H.S.D., MPH, CHES, Consultant, Health Education, was appointed as Grant Officer who assisted the seven consortia in designating staff and coordinated their participation in the New Jersey Immunization Information System (NJIIS) Registry trainings in Mt. Laurel and Newark. Accordingly, 15 MCHC staff members were trained who initiated immunization activities for a six-month period effective July 1, 2003 to December 31, 2003.

Initially, each consortium was required to submit a "List of Pediatric Providers," and an "Immunization Action Plan." The Action Plan indicated objectives, methodology, implementation and the evaluation components of each project. Each agency submitted Grant Quarterly Progress Reports for the First and the Second Quarters. The consortia were advised to report the number of pediatric providers contacted, and the number of children enrolled into the NJIIS Registry for each quarter. Based on the submitted reports, 1,323 pediatric providers were contacted and 8,837 children were enrolled into the NJIIS Registry. The MCHC Immunization Project was a joint activity of the Perinatal Health Services Program, Division of Family Health Services, and the Immunization Program, Division of Communicable Diseases, terminated on December 31, 2003. For Year 2004, the Immunization Program initiated new grants directly with the Maternal and Child Health Consortia based on their success with the pilot projects.

c. Plan for the Coming Year

FHS continues to work collaboratively with the Immunization Program to promote age appropriate immunizations. All newborn infants in New Jersey will be automatically entered into

the system at birth via the Electronic Birth Certificate to permit tracking of population-based immunization rates and to promote the completion of immunization schedules through record sharing. Interfaces with private insurance carriers and physician offices will also contribute to populating the registry.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

a. Last Year's Accomplishments

Seventeen family planning agencies with 60 clinical sites provided comprehensive reproductive health services to over 33,000 adolescents each year to assist the Title V program to meet National Performance Measure # 8, reduction of births to teens 15 - 17 years of age. Clinical services are provided including physical assessment, laboratory testing and individual education and counseling for all FDA approved contraceptive methods.

Family planning agencies also provided community education and outreach to the adolescent population. Aimed at schools and community groups, educational activities that deal with decision-making, value clarification and establishing linkages with youth-serving agencies were encouraged. Educational activities focused on primary pregnancy prevention activities that encourage family communication, promoting self-esteem, postponing sexual activity and promoting effective contraception. All family planning agencies have implemented an enhanced service package, which for Medicaid beneficiaries is a reimbursable service. The program integrates assessment of adolescent risk behavior within routine family planning services. Through direct individual preventive education or through referral, the program promotes behaviors of healthy lifestyle, injury prevention, drug, alcohol and tobacco prevention, as well as sexually transmitted disease (STD) and pregnancy prevention.

MCH resources also continue to support a Young Fathers Program in Newark. The Program provides counseling services to young men between the ages of 15-23 years to enhance their social and emotional functioning, increase their financial independence, and promote responsible behavior.

See Chart #4 Teen Births (Ages 15-17) by Race/Ethnicity attached to Section I.D. Table of Contents.

b. Current Activities

In addressing NPM # 8 Teen (15-17) Birth Rate, collaboration with the Department of Human Services, the Department of Education, the Department of Labor and the Juvenile Justice Commission relative to teen pregnancy prevention activities continues to focus on the promotion and development of statewide County Collaborative Coalitions. Regional forums continue to be held which bring together stakeholders from a variety of agencies and organizations to envision, plan and implement local adolescent pregnancy prevention activities and events for Teen Pregnancy Prevention Month (May).

Additionally, this interdepartmental workgroup continues to facilitate cohesive, integrated statewide systems that provide comprehensive pregnancy, prevention services for young people. Presently, the workgroup is drafting a long-range strategic plan, which supports the goals and objectives of sustained adolescent pregnancy prevention services and strategies. Also, intradepartmental planning is underway for the 8th Annual Day of Learning which has recently broadened in scope to include peer leadership training on teen pregnancy and HIV/STD prevention. As a result, this program is now referred to as the Teen Prevention and Education Program (Teen PEP), and a "Day of Learning" has been held annually in May to highlight pregnancy prevention month.

Annually, the interdepartmental workgroup co-sponsors an Adolescent Health Institute in November. This one-day program was established for the purpose of bringing together adolescent stakeholders from throughout the state who are given an opportunity to participate in a forum that will provide up-to-date information and resources as they pertain to the many issues and challenges facing New Jersey youth.

c. Plan for the Coming Year

Family planning agencies with 60 clinical sites will continue to provide comprehensive reproductive health services to over 33,000 adolescents each year to assist the Title V program to meet National Performance Measure # 8, reduction of births to teens 15 - 17 years of age. MCH resources also continue to support a Young Fathers Program in Newark. The 6th Annual Adolescent Health Institute is scheduled for November 2004. Activities of the Teen Prevention and Education Program will continue and the "Day of Learning" will be held in May 2004.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

a. Last Year's Accomplishments

In the area of oral/dental health, support continues for three regional programs that employ dental hygienists who act as regional dental coordinators providing oral health education to preschool and elementary school students through the Cavity Free Kids program and Save Our Smiles, a school fluoride mouth rinse program, serving over 125,000 children. These programs were expanded in 2002 with state funds. A Directory of Fluoridated Water Systems was published and disseminated to dentists in cooperation with the New Jersey Dental Society. The Directory is also available on the Department's web site. A survey of third grade children in a sample of 46 elementary schools conducted in January 2001, found that 42% of parents reported their child had protective sealants on at least one permanent molar. The sealant survey of third grade children was repeated in early 2003 and found the similar result that 42.6% of parents reported their child had protective sealants on at least one permanent molar.

b. Current Activities

The Federally Qualified Health Centers (FQHC) Expansion program continues to provide financial support of dental health services. Additionally, the Physician/Dentist Loan Redemption Program has placed 11 more dentists in underserved areas of the State. DHSS and regional oral health staff participated in the statewide "Give Kids a Smile" day in January 2004.

c. Plan for the Coming Year

To improve pediatric oral/dental health, the Cavity Free Kids program and the Save Our Smiles program will continue to provide oral health education to preschool and elementary school students. The FQHC Expansion program will continue to provide financial support of dental health services and the Physician/Dentist Loan Redemption Program will work to place more dentists in underserved areas of the State. Collaboration will continue with the New Jersey Dental School and the New Jersey Dental Association to plan and promote "Give Kids a Smile Day" in 2005. The state supported FQHC capacity building effort will work to increase access to dental services.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by*

motor vehicle crashes per 100,000 children.

a. Last Year's Accomplishments

The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes has declined since 1997 both in New Jersey and in the United States.

b. Current Activities

Although not specifically focused on deaths due to motor vehicle crashes, progress has been made on unintentional injury prevention activities. The Prevention Oriented Services for Child Health (POrSCHe) projects instruct families in child safety including use of infant car seats and child restraint systems. Safety at home and in the childcare center is one of the major focuses of the Healthy ChildCare New Jersey Initiative.

c. Plan for the Coming Year

POrSCHe projects will continue in the coming year to instruct families in child safety including use of infant car seats and child restraint systems. The Healthy ChildCare New Jersey Initiative will continue to emphasize safety at home and in the childcare center.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

a. Last Year's Accomplishments

In Healthy New Jersey 2010, there are two objectives for breastfeeding: 1) to increase the proportion of mothers who breastfeed their babies at hospital discharge to at least 75.0 percent and 2) to increase the proportion of the breastfeeding women whose infants are breastfed exclusively at hospital discharge to 90.0 percent. Two additional national breastfeeding objectives are for 50% of new mothers to continue breastfeeding until their infants are six months old and for 25% to breastfeed until one year.

Despite the overwhelming evidence supporting the numerous benefits of breastfeeding, exclusive breastfeeding rates in the 24 hours prior to hospital discharge in New Jersey have declined since 1998, while combination feeding (both breastfeeding and formula feeding) rates have increased, yielding an overall increase in breastfeeding initiation rates (chart 13). In 2002, exclusive breastfeeding at hospital discharge statewide was 38.7% (range from 1.6% to 78.4%) while any breastfeeding (exclusive and combination feeding) was 66.0% (range from 16.7% to 90.8%). In 2002, 19 of 64 delivery hospitals meet the objective for 75% breastfeeding on discharge and four hospitals had 90 percent of its breastfeeding as exclusive. Three hospitals met both of New Jersey's objectives for 2010.

Breastfeeding rates on discharge varied with the minority composition of mothers. In 2002, the any breastfeeding rates were 67.9% for white non-Hispanic women, 68.5% for Hispanic women, and 46.3% for black non-Hispanic women (chart 14). The exclusive rates were 49.2% for white non-Hispanic women, 24.9% for Hispanic women and 21.6% for black non-Hispanic women (chart 15).

Further examination of the disparity in these rates will require information of locally available breastfeeding promotional activities, protocols, and the cultural appropriateness of those services. Hospitals that follow the "Ten steps to successful breastfeeding" (WHO/UNICEF) have better breastfeeding on discharge rates.

Collaborative initiatives are underway to promote breastfeeding and improve breastfeeding

duration. Several hospitals employ International Board Certified Lactation Consultants who can identify early signs of breastfeeding difficulties and suggest appropriate options to the patients and medical staff. WIC Services funds breastfeeding promotion and support services for WIC participants through grants to five local WIC agencies and four MCH Consortia. WIC lactation consultants and breastfeeding peer counselors provide direct education and support services, literature, education and breastfeeding aids, including breast pumps, breast shells and other breastfeeding aids. WIC breastfeeding staff provides professional outreach and education to healthcare providers who serve WIC participants.

See Chart #9 Breastfeeding at Hospital Discharge by Race abd Ethnicity attached to Section I.D. Table of Contents.

b. Current Activities

During 2002-2003, the Integrating Breastfeeding Education to Eliminate Disparities (IBEED) Project, through a Health Resources and Services Administration (HRSA) grant, was piloted at six hospitals in New Jersey. The primary goal of the project was to increase exclusive breastfeeding rates at targeted delivery hospitals through an integrated approach to breastfeeding education and training for health professionals. The secondary goal was to eliminate breastfeeding disparities by developing best practices in postpartum care and implementing a curriculum that is culturally competent. The objectives of the project were to:
- Improve the knowledge and attitudes related to breastfeeding of health care professionals who care for mothers and infants in targeted delivery hospitals.
- Educate health care professionals on strategies for communicating the benefits of breastfeeding and rationale for exclusive breastfeeding to their patients.
- Create a technology driven ongoing forum for dispensing new research, optimal policies and practices for breastfeeding care in the postpartum period.
- Enhance post-graduate education and training in breastfeeding for residency programs in pediatrics, obstetrics/gynecology, and family medicine.
- Develop curriculum and case-based teaching that is appropriate for various cultures.
- Introduce the concept of cultural competency and develop quality assurance measures that ensure delivery of culturally competent breastfeeding related care.

The project was highly successful. Four of the six hospitals significantly increased their any breastfeeding rates and five of the six increased their exclusive rates. The following chart compares the any and exclusive breastfeeding rates in the first quarter of 2002 before the project began with the second quarter of 2003 when the project concluded at the six New Jersey project hospitals. For comparison, data for five control hospitals is also included for the same time periods.

See attached Chart for Performance Measure 11.

The IBEED Project showed success in interdisciplinary cooperation within the pilot hospitals and an interest in developing evidence-based breastfeeding protocols. Expanding IBEED to include all delivery hospitals in New Jersey would help to make breastfeeding the norm for infant feeding in the State.

c. Plan for the Coming Year

In the spring of 2004, the Department of Health and Human Services Office on Women's Health is expected to launch a national campaign to promote exclusive breastfeeding for six months. The campaign messages are the result of focus groups conducted around the country and will target women who have no firm commitment to breastfeeding or formula feeding, and in particular, African American women. WIC Services and many healthcare providers are

planning to capitalize on the renewed interest in breastfeeding that this campaign is expected to generate.

To improve the percentage of women who exclusively breastfeed their infants at hospital discharge, the Maternal and Child Health Consortia will be provided a method to assist with ongoing breastfeeding education and training for hospital staff and methods for ongoing monitoring of practices supportive of breastfeeding in a culturally and linguistically diverse population, using a tool developed through the IBEED Project.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

a. Last Year's Accomplishments

The statewide implementation of an Electronic Birth Certificate (EBC) in 1997 now permits the Early Hearing Detection and Intervention (EHDI) Program to monitor the percent of newborns screened for hearing impairment before hospital discharge (National Performance Measure #12).
Current data indicates that for 2003, 98% of infants were screened prior to discharge.

b. Current Activities

Using the EBC, the EHDI can also identify and track children at "high-risk" for hearing loss and those who failed initial electrophysiological screening tests. Newborn hearing screening rules with amendments were readopted effective May 15, 2000. The amended regulations include: 1) a requirement for all birthing facilities to provide electrophysiological hearing screening prior to discharge or before one month of age for all babies having indicators associated with hearing loss, and 2) a requirement for all birthing facilities to screen all newborns electrophysiologically, regardless of the presence or absence of risk factors, prior to discharge or before one month of age by the year 2002. All facilities must have a system of follow-up in place for infants who failed the screen. In January 2002, legislation was enacted mandating universal newborn electrophysiological hearing screening. The legislation reinforces the State's commitment to early identification of hearing loss and early entry into treatment/intervention.

In March 2002, SCAEIS received a 4-year grant from HRSA for Universal Newborn Hearing Screening. The focus of the grant is to strengthen the follow-up system for infants failing their hearing screens, and to provide findings to SPAN to increase the number of support parents for children with hearing loss from 10 to 75. From July 2001 to the present, the Newborn Screening and Genetic Services Program together with the Inborn Errors of Metabolism Laboratory at the NJDHSS, has partnered with several agencies, including individual hospitals, physician groups, health care advocacy organizations and others to present information and education on the expansion of newborn biochemical screening services.

Site visits to all 64 active birthing facilities in the State we made during 2003 by the EHDI staff to observe screenings, review procedures, provide technical assistance and give suggestions for improvement in screening and follow-up. Quarterly reports were distributed to all hospitals comparing hospital performance to statewide averages and detailing children still needing follow-up. Educational programs were presented to physicians, nurses, early intervention staff, case managers, and hospital EBC staff. Worked through Statewide Parent Advocacy Network to increase trained parent-to-parent support providers for children with hearing impairment. Staff began drafting guidelines for early intervention providers for working with hearing impaired children.

c. Plan for the Coming Year

The EHDI program will increase efforts at improving follow-up rates, improve tracking through the system to Early Intervention services, conduct educational programs for professionals, and develop new and improved parent education materials.

Performance Measure 13: *Percent of children without health insurance.*

a. Last Year's Accomplishments

Improving access to preventive and primary care health services for children is a departmental and divisional priority. To provide comprehensive and affordable health insurance to eligible uninsured children, New Jersey and the Federal government have joined as partners in NJ FamilyCare (formerly New Jersey KidCare). NJ FamilyCare, administered by the New Jersey Department of Human Services, started in 1998. As of March 2004 there were 98,850 children enrolled in the newly expanded NJ FamilyCare initiative and 68,795 adults enrolled in the NJ FamilyCare program. In the course of developing NJ FamilyCare, the State learned that many poor children who are eligible for free health insurance under the State's Medicaid program are not enrolled. The aggressive marketing and outreach programs designed to enroll children in NJ FamilyCare are also being used to increase the number of children enrolled in Medicaid. If all children who are eligible for NJ FamilyCare or Medicaid enroll in these programs, then the percentage of children who are uninsured should drop to four percent. Of the approximately four percent of uninsured children who do not qualify for NJ FamilyCare or Medicaid, many experience temporary gaps in insurance coverage, usually as a result of changes in parental employment. If employer-sponsored health insurance continues to decline, NJ FamilyCare will not be able to reduce the overall number of uninsured children in the State. Unfortunately, the percentage of uninsured children in New Jersey has increased from 8.2% in 1999 to 10.1% in 2002.

b. Current Activities

To reduce the number of uninsured children in New Jersey (National Performance Measure #13), the Department of Health and Senior Services continues our collaborative relationship with the Department of Human Services, the lead agency for the NJ FamilyCare Initiative. Title V has included language within our specifications for health service grants to require agencies providing health enabling services to outreach and facilitate enrollment of potentially eligible children.

To address the limited enrollment of adolescents in New Jersey FamilyCare, NJDHSS is collaborating with the Department of Human Services and the Region II Field Office of the Health Resources and Services Administration (HRSA) in the NJ Family Care: Adolescent Enrollment and Utilization of Health Services project. While some outreach and enrollment activities have been targeted toward this population group through schools, these achieved limited success. Under the HRSA/Center for Medicare and Medicaid Services CompCare initiative, consultants from Health Systems Research, Inc. have interviewed State staff and key community informants, conducted focus groups with adolescents and parents, and are developing recommendations for addressing the barriers to adolescent enrollment in health insurance and utilization of appropriate health services. In 2003-04, this initiative has shifted focus to researching effective measures to outreach to New Jersey's large and diverse immigrant population.

c. Plan for the Coming Year

DHSS will continue to collaborate with the Department of Human Services, the lead agency for the NJ FamilyCare Initiative, to reduce the number of uninsured children. Under the

HRSA/Center for Medicare and Medicaid Services CompCare initiative, consultants from Health Systems Research, Inc. have interviewed State staff and key community informants, conducted focus groups with adolescents and parents, and are developing recommendations for addressing the barriers to adolescent enrollment in health insurance and utilization of appropriate health services. Recommendations are also being developed for outreach to the diverse immigrant populations in New Jersey.

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

a. Last Year's Accomplishments

The Medicaid program in New Jersey is administered by the Division of Medical Assistance and Health Services in the Department of Human Services. The percentage of potentially-eligible children who have received a service paid by the Medicaid Program (97.3% in May 2004) is reported monthly by the Office of Statistical Analysis and Managed Care Reimbursement.

b. Current Activities

The Prevention Oriented Services for Child Health projects (POrSCHe) continue in 11 of New Jersey's 21 counties. Six of the target areas are cities and five of the projects are county-based. The initiative began in January 1997. Approximately 1,100 families are being served annually by POrSCHe projects. The POrSCHe projects were designed as outreach case management models to assist primary health care providers. Through POrSCHe, families are provided services that include: identification of health, nutritional, or developmental problems; supportive anticipatory guidance in child growth and development and parenting skills training and counseling; specialized health education to promote age appropriate immunizations, healthy eating and safety habits including, but not limited, to car seat restraints; and regular health supervision visits to a primary care provider. Additionally, the home visitor provides assistance to parents in accessing community resources (WIC, Family Planning, housing, education, job training and other social services). Evaluation of the projects is based on performance and outcome measures including: linkage with a primary care provider; enrollment in WIC, Medicaid (NPM #14), age appropriate immunizations (NPM #7) and lead screening (SPM #3); follow-up to ensure decreasing blood lead levels for affected children; referral for all appropriate services; and increase in parenting skills as measured by Nursing Child Assessment Satellite Training (NCAST) instruments.

DHSS collaborated with the NJ Department of Human Services (DHS), Division of Medical Assistance and Health Services, in the development of materials promoting the use of preventive health services for children, particularly those covered under the Early and Periodic Screening, Diagnosis and Treatment program (EPSDT). These materials are distributed through DHSS-funded child health projects and through the HMOs that have DHS contracts to provide primary care to children enrolled in Medicaid.

c. Plan for the Coming Year

The Prevention Oriented Services for Child Health projects (POrSCHe) will continue in target areas.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

a. Last Year's Accomplishments

HealthStart prenatal providers have continued to provide comprehensive health services and maternity and newborn services in order to address very low birth weight live births (PM #15), very low birth weight infants delivered at facilities for high-risk deliveries (PM #17), and first trimester prenatal care (PM #18). The HealthStart prenatal care providers include 70 hospitals that provide maternity services; six HMOs contracted through the Department of Human Services, 12 private physician practices, 11 FQHCs, four Planned Parenthood agencies, and three licensed ambulatory care agencies. All of the facilities are certified by Medicaid to provide HealthStart maternity services, and 90 are certified to provide presumptive eligibility screening.

The role of preconceptual health and its impact on preterm birth, low birth weight (LBW) and very low birth weight (VLBW) has gained more attention. The Perinatal Health Services Program coordinated the Folic Acid Coalition of New Jersey Annual Meeting that was held on April 30, 2003 in Trenton. During the meeting, the "Folic Acid/March of Dimes National Brand Study - New Jersey", the March of Dimes Prematurity Initiative and the "National Council on Folic Acid Strategic Plan 2002-2005," and other activities for Year 2003 were reviewed. Accordingly, the Annual Folic Acid Awareness Day - 2003 was sponsored by the March of Dimes in Jersey Gardens Outlet Mall in Elizabeth on July 19, 2003. Approximately, 1,500 persons were reached with the folic acid message. In addition, the Perinatal Health Services Program mailed 3,100 folic acid flyers in English and Spanish to target group populations through the eight Healthy Mothers/Healthy Babies (HM/HB) Coalitions.

In 2003, the Perinatal Health Services Program continued its emphasis on the Preconceptional Health Initiative as it impacts prematurity, low birth weight (LBW), and very low birth weight (VLBW) deliveries. A total of four preconceptional health risk factors, i.e., physical inactivity and smoking during pregnancy, lack of folic acid intake and Postpartum Depression (PPD) received emphasis. The seven Maternal and Child Health Consortia (MCHC), the eight HM/HB Coalitions and the Family Health Line that operates the 24/7(1-800-328-3838) hotline served as active channels for reaching prospective pregnant women.

The HM/HB Coalitions continued to play a key role in integrating preconceptional health with their on-going MCH programs, applying mass media, community event, health fair and group activity methods to reach the target group populations. The Perinatal Health Services Program provided 8,585 brochures, i.e., 5,485 related to preconceptional health and 3,100 related to folic acid to these agencies for statewide dissemination. In addition, 1,505 Postpartum Depression (PPD) brochures, and 4,895 Maternal, Child and Community Health (MCCH) Services unit brochures were disseminated making a grand total of 14,985 for Year 2003.

b. Current Activities

The Year 2004 Action Plan for the Preconceptional Health Promotion Initiative includes emphasis on newly selected preconceptional health risk factors, i.e., prematurity and lack of folic acid intake by prospective pregnant women and adults of childbearing age. Based on the above Action Plan, 5,000-10,000 pertinent brochures are planned for dissemination during Year 2004.

c. Plan for the Coming Year

The MCH Consortia, Healthy Mothers/Healthy Babies (HM/HB) Coalitions and the Family Health Line will continue to reach prospective pregnant women and to address issues related to LBW. Additional preconceptional health risk factors will be selected for emphasis in the Year 2005 Action Plan for the Preconceptional Health Promotion Initiative.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

a. Last Year's Accomplishments

DHSS supports the Mercer County Traumatic Loss Coalition, which brings together a wide variety of community partners (including schools, local government, police, fire and EMS, and health care providers) to develop plans to prevent and address suicide and other sudden traumatic death among children and adolescents. Since FY 2001 state funds have been budgeted to replicate this coalition in the other 20 counties in New Jersey.

b. Current Activities

"Managing Sudden Traumatic Loss in the Schools" (revised edition) is made available to schools and other youth serving organizations upon request. The document outlines a model for responding to the needs of the general school population after a suicide, homicide or sudden accidental death.

c. Plan for the Coming Year

DHSS will continue to work with a wide variety of community partners, such as the Mercer County Traumatic Loss Coalition, to develop plans to prevent and address suicide and other sudden traumatic death among children and adolescents.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

a. Last Year's Accomplishments

The state has made consistent progress on NPM #17. However, despite improvements in Neonatal Intensive Care Units (NICU) and community-base efforts that focus on early admissions to prenatal care and comprehensive services, we have not observed improvements in the rate of infants born at low birth weights. Overall trends in both low and very low birth weights indicate a small but steady increase in the number of infants born at these weights. A significant refinement in the reporting of LBW rates is the reporting of singleton LBW and singleton VLBW rates as Health Status Indicators. The rapid increase in multiple births due to assisted reproductive technology has influenced overall LBW and VLBW rates. Singleton LBW and singleton VLBW rates are stable or slightly decreasing.

b. Current Activities

The percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates (PM #17) has increased through continuous quality improvement (CQI) activities which are coordinated on the regional level by the Maternal and Child Health Consortia (MCHC). The FHS/Perinatal Services coordinates regional continuous quality improvement activities within each of the seven regional maternal and child health consortia. Regional quality improvement includes the regular collection and analysis of data, designed to identify the nature and severity of health-service problems. Regional quality improvement activities include regular monitoring of indicators of perinatal and pediatric statistics and pathology, including 1) transports with death; 2) non-compliance with rules regarding birth weight and gestational age; 3) cases in which no prenatal care was received; 4) all maternal deaths; 5) all fetal deaths over 2,500 grams not diagnosed as having known lethal anomalies; 6) selected pediatric deaths and/or adverse outcomes; 7) immunizations of children two years of age; and 8) admissions for ambulatory care sensitive diagnoses in children.

Quality improvement is accomplished through fetal-infant mortality review and maternal mortality review systems, as well as analyzing data collected through the electronic birth certificate. The MCH Consortia recommend, implement, and monitor corrective action, based upon the data collected. A multidisciplinary committee that includes representation from member hospitals and the community oversees the total quality improvement process within the Consortium. Data collected through the EBC and the New Jersey Maternal Mortality Review and New Jersey Fetal-Infant Mortality Review are presented to the Consortium TQI Committee. The TQI Committee reviews the data and makes recommendations to address either provider specific issues or broad system issues that address multiple providers or consumer groups within each Consortium region. Data and information gleaned from regional TQI activities is forwarded to the Department of Health and Senior Services, Maternal, Child and Community Health/Perinatal Health Services, which will be included in a combined database used for planning on a statewide level.

The New Jersey March of Dimes Prematurity Campaign is a partnership between Johnson and Johnson Pediatric Institute, American College of Obstetricians and Gynecologists, Association of Women's Health, Obstetric and Neonatal Nurses, American Academy of Pediatrics, Matria and the Department of Health and Senior Services, Division of Family Health Services. The Division of Family Health Services maintains a seat on the statewide planning committee for activities around this initiative. The First New Jersey Prematurity Summit was held in March 2003 with over 100 health care professionals attending. Subsequent activities have been held to bring public attention to the issue of prematurity.

c. Plan for the Coming Year

The Department is convening a Maternal and Child Task Force on Hospital-based Perinatal and Pediatric Services. The Task Force is being convened by the Department to examine whether the current regulatory system, including certificate of need and licensure rules, governing hospital-based perinatal, neonatal and pediatric services, is consistent with changes in medical practice. Nominations for membership on the Task Force were solicited from various constituencies involved with maternal, child and family health. Nominees have a wide range of expertise including physicians, nurses, administrators and other disciplines. The Division will continue to participate on the March of Dimes Prematurity Campaign statewide planning committee. The Perinatal Health Services Program Manager is participating on the planning committee for the Fall 2004 Prematurity Summit.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

a. Last Year's Accomplishments

Through the Healthy Mothers/Healthy Babies (HM/HB) Coalition program, the enabling services of outreach, supportive services, and education are provided to improve maternal and infant care (National Performance Measures #18, #5, #17, and Health Status Indicators #2, #3, #4, #5). The percentage of infants born to pregnant women receiving prenatal care beginning in the first trimester and the percentage of infants born to pregnant women receiving adequate prenatal care (Kotelchuck Index) have increased in 2002.

See Chart #2 First Trimester Prenatal Care Initiation by Race/Ethnicity attached to Section I.D. Table of Contents.

b. Current Activities

The Southern New Jersey Perinatal Cooperative in conjunction with the Atlantic City HM/HB

Coalition is providing bilingual outreach workers accompanied by bilingual interpreters to perform door-to-door canvassing and educational activities. This program locates women who have missed prenatal appointments and assists new mothers in obtaining pediatric care for their children. Age appropriate immunizations and comprehensive pediatric and prenatal care are the focus of the outreach activities. The target is approximately 200 referrals to services annually. The Camden HM/HB Coalition uses the canvassing and referrals to identify women between the ages of 20 and 35 who are in need of more intensive contact based on initial evaluation and to subsequently enroll them in case management. Pregnant women not in care are identified. Health Advocates will assist in making appointments and appropriate referrals for these women and will provide follow-up care. Barriers to care are identified and reported to their Community Network Committee.

In the Northern New Jersey Maternal and Child Health Consortium, the Paterson HM/HB Coalition operates a Safety Net Program. This Program is designed to reduce infant morbidity and mortality through a collaborative patient retrieval effort. An Outreach Worker assists local providers in locating women and children delinquent in obtaining scheduled health care. The Outreach Worker attempts to locate the client, advise them of the benefits of returning to care and assists the client in complying with the scheduled plan of care. Women are also identified through door-to-door canvassing and receive prenatal or preconceptional education and referrals. The goal is to identify and educate 500 women on the benefits and availability of care.

c. Plan for the Coming Year

The enabling services of outreach, supportive services, and education will continue to be provided to improve prenatal care through the Healthy Mothers/Healthy Babies (HM/HB) Coalition program.

FIGURE 4A, NATIONAL PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET

General Instructions/Notes:

List major activities for your performance measures and identify the level of service for these activities. Activity descriptions have a limit of 100 characters.

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.				
1. 1. /2005/ Expanded screenings to include 20 newborn biochemical disorders	☐	☐	☑	☐
2. Tandem mass spectrometry technology has been implemented in the Inborn Errors of Metabolism Lab	☐	☐	☑	☐
3. Regional specialty care centers have been established & supported for affected babies & their famili	☐	☐	☐	☑
4. Ongoing collaboration with specialists & general primary care providers	☐	☐	☐	☑
5. FHS and Public Health and Environmental Lab staff regularly meet meet with established speciality co	☐	☐	☐	☑

6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)				
1. SPAN	☐	☐	☐	☑
2. Parent-to-Parent Network	☐	☐	☐	☑
3. Statewide Family Voices chapter	☐	☐	☐	☑
4.	☐	☐	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)				
1. Case Management Services	☐	☑	☐	☐
2. Your Voice Counts	☐	☑	☐	☐
3. Medicaid Managed Care Alliances	☐	☑	☐	☐
4. Subsidized Direct Specialty and Subspecialty Services	☐	☑	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public				

insurance to pay for the services they need. (CSHCN Survey)				
1. County Case Management	☐	☐	☐	☑
2. Subsidized Direct Specialty and Subspecialty Services	☐	☐	☐	☑
3.	☐	☐	☐	☐
4.	☐	☐	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)				
1. Statewide Parents Advocacy Network	☐	☑	☐	☐
2. Parent-to-Parent Network	☐	☑	☐	☐
3. Family Voices parent group	☐	☑	☐	☐
4.	☐	☐	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)				
1. Transition for sickle cell youth	☑	☐	☐	☐
2. Transition planning for youth with hemophilia	☑	☐	☐	☐
3.	☐	☐	☐	☐
4.	☐	☐	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐

9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.				
1. Immunization Program in Communicable Disease	☐	☐	☑	☐
2. NJIIS web-based registry	☐	☐	☐	☑
3. NJ Vaccines for Children Program	☐	☐	☑	☐
4. Local health department child health conferences	☐	☐	☐	☑
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) The rate of birth (per 1,000) for teenagers aged 15 through 17 years.				
1. Family Planning Agencies providing comprehensive reproductive services	☐	☐	☑	☐
2. Collaborate with Dept. of Human Services Adolescent Pregnancy Prevention Program	☐	☐	☑	☐
3. Adolescent Pregnancy Prevention Advisory Council	☐	☐	☑	☐
4.	☐	☐	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
9) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.				
1. Federally Qualified Health Center (FQHC) Expansion	☐	☐	☑	☐
2. Physician/Dentist Loan Redemption Program	☐	☐	☑	☐

3. Regional Oral Health Promotion Programs	☐	☐	☑	☐
4. 4. /2005/ Give Kids a Smile Day	☐	☐	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
10) The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.				
1. POrSCHe home visiting projects	☐	☐	☑	☐
2. Healthy Child Care Initiative safety focus	☐	☐	☑	☐
3.	☐	☐	☐	☐
4.	☐	☐	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
11) Percentage of mothers who breastfeed their infants at hospital discharge.				
1. Professional outreach and education through MCH Consortia	☐	☐	☐	☑
2. WIC funding of MCHC and local WIC agencies	☐	☐	☑	☐
3. Surveillance from EBC & applied research projects	☐	☐	☐	☑
4. Integrating Breastfeeding Education to Eliminate Disparities Project (IBEED)	☐	☐	☐	☑
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

12) Percentage of newborns who have been screened for hearing before hospital discharge.				
1. Amended regulation for universal screening	☐	☐	☑	☐
2. Hospital level surveillance reports	☐	☐	☑	☐
3. Increase in follow up and diagnostic reporting for those who fail screening	☐	☐	☑	☐
4.	☐	☐	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
13) Percent of children without health insurance.				
1. Outreach and Enrollment Plan	☐	☐	☐	☑
2. MOU with NJ FamilyCare	☐	☐	☐	☑
3.	☐	☐	☐	☐
4.	☐	☐	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
14) Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.				
1. Collaborate with Department of Human Services on EPSDT promotion activities	☐	☐	☐	☑
2. NJ CompCare project	☐	☐	☐	☑
3. POrSCHe case management projects	☐	☐	☐	☑
4.	☐	☐	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐

9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
15) The percent of very low birth weight infants among all live births.				
1. HealthStart	☐	☐	☐	☑
2. Preconceptual health counseling/training	☐	☐	☐	☑
3. Healthy Mothers / Healthy Babies coalition activities	☐	☐	☐	☑
4. Healthy Start	☐	☐	☐	☑
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
16) The rate (per 100,000) of suicide deaths among youths aged 15 through 19.				
1. NJ Suicide Planning Team	☐	☐	☐	☑
2. Traumatic Loss Coalitions in 21 counties	☐	☐	☑	☐
3.	☐	☐	☐	☐
4.	☐	☐	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				
1. MCH Consortia TQI Activities	☐	☐	☐	☑
2. Perinatal Designation Level regulations	☐	☐	☐	☑
3. MCH Task Force on Hospital-based perinatal and pediatric services	☐	☐	☐	☑
4.	☐	☐	☐	☐
5.	☐	☐	☐	☐

6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.				
1. Healthy Mothers / Healthy Babies coalition activities	☐	☐	☐	☐
2. MCH Consortia outreach and education activities	☐	☐	☐	☐
3. HealthyStart	☐	☐	☐	☐
4.	☐	☐	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *Percent of Black Preterm Births*

a. Last Year's Accomplishments

Maternal, Child and Community Health chose the percent of black preterm births in New Jersey as State Performance Measure #1. Previous sections concerning the Blue Ribbon Panel on Black Infant Mortality Reduction, the Black Infant Mortality Reduction Advisory Council, the BIBS campaign and MCH activities demonstrate the department's commitment to reduce black infant mortality. Infants who are born preterm are at the highest risk for infant mortality and morbidity. The percentage of black preterm births was selected to begin to address the underlying causes of black infant mortality and the racial disparity between preterm birth rates.

b. Current Activities

The Perinatal Health Services Program requested that the Black Infant Mortality Resource Center Program Director network with the seven funded projects to develop an assessment of activities statewide through the funded projects and to assist with program evaluation. In an effort to share resources and to leverage funds, the Director was requested to provide a review of all of the services of the Resource Center to the funded projects. The Director provided consultation and technical assistance for outreach and education projects.

c. Plan for the Coming Year

Based on the assessment performed by the Black Infant Mortality Resource Center, two meetings will be convened by the Center for participation by all of the funded projects. This will

provide an opportunity for the projects to network and share "lessons learned". In addition, funded projects will review the data from the projects to determine the most effective means of client recruitment and retention.

State Performance Measure 2: *Percentage of regional MCH Consortia implementing community-based Fetal and Infant Mortality Review Teams*

a. Last Year's Accomplishments

State Performance Measure #2 was selected to monitor progress toward the implementation of community-based Fetal and Infant Mortality Review Teams (FIMR). This infrastructure building service will impact on National Performance Measures #15, #17, #18 and all of the perinatal outcome measures. Increasing the understanding of the circumstances and factors associated with fetal and infant deaths will advance the State's ability to assess needs, improve the social and health care delivery system, and target resources and policies toward specific locations.

Related to FIMR is New Jersey's system of Maternal Mortality Review (MMR), which was established, in the late 1970s. In collaboration with a subcommittee of the Medical Society, the MMR was completed annually. However, the need to expand the MMR review team, utilize consistent case abstractions and complete reviews on a more timely basis was identified as a need by the Division last year. Using Florida's MMR system as a model, New Jersey began the task of revising our system. In collaboration with the Chair of the MMR subcommittee of the Medical Society, staff drafted a revised MMR protocol and presented the protocol to the full committee in May 1999. A request for proposals seeking to support the coordination of the MMR state activities and the preparation of uniform abstracts was released by DHSS in the spring of 1999. The Central New Jersey MCHC was awarded the grant to implement the new system. Representatives from MCCH, the seven MCHC, and the Medical Society of New Jersey comprise the steering committee. The case review team membership was solicited from the seven MCHC and a variety of professional organizations throughout the State.

The FHS/Perinatal Services coordinates the New Jersey MMR process. The New Jersey MMR Program is a statewide initiative modeled after the National FIMR process. This process uses standardized data collection and a multidisciplinary team for case review. In addition, a birth certificate, death certificate and hospital discharge data matching strategy is used to improve identification of maternal deaths using the CDC expanded definition of pregnancy-associated death.

Once cases are identified, Perinatal Services obtains copies of death certificates, which are forwarded to the Central NJ Maternal and Child Health Consortia (CNJMCHC). The CNJMCHC coordinates data abstraction through a grant from DHSS. Data abstractors are nurses with extensive maternal and child health backgrounds, trained in medical data abstraction, and case summary development. Each MCH Consortia identify qualified individuals to act as a data abstractor for deaths that occurred within the consortium's region. The data abstractor's attend an annual training to review policies and procedures, discuss issues related to data abstraction, and receive an update on the review process.

b. Current Activities

The number of FIMR projects statewide continues to be nine, of which seven are funded with MCH block grant monies through the seven regional maternal and child health consortia. In order to assure a process that will allow for coordination of New Jersey FIMR findings from a statewide perspective, the process is implemented uniformly across all projects. All local projects of New Jersey FIMR follow the National FIMR guidelines for community FIMR with modifications as needed for New Jersey. The data collection process includes both chart

abstraction and a maternal interview. A multidisciplinary case review team reviews the information and based on findings, makes recommendations to a Community Action Team. Data and findings from FIMR projects are submitted to the NJDHSS for inclusion in a statewide database.

Obtaining the maternal interview has proven to be an impediment to the process. Over this past year, all projects were requested to use public health nurses to obtain the maternal interview by contracting with a local health department or VNA to see if using professionals with community home visiting skills will increase the success rate.

On a local level, the MCH Consortia have used FIMR as a component of their quality improvement program both for need assessment and program development. Findings are shared with member hospitals for use in quality assurance activities. Policy has been implemented, such as the promulgation of fetal autopsy guidelines and consumer and professional education initiatives have addressed findings such as inadequate knowledge of fetal kick count and premature labor, and bereavement support issues.

Until the implementation of the New Jersey FIMR, there has not been a statewide approach to FIMR. Therefore, FIMR findings have not played a major role in need assessment and quality improvement at the state level. NJDHSS and the MCH Consortia are now working collaboratively to use the information obtained from New Jersey FIMR for policy development and continuous quality improvement activities on the state and local level. In addition to issuing a Statewide Annual New Jersey FIMR report, common areas of concern identified from the local reviews will be addressed as a collaborative effort by all local projects through statewide initiatives.

Concerning MMR, all pregnancy-associated deaths occurring in 1999 and 2000 have been reviewed. Of the 106 pregnancy associated deaths confirmed and reviewed by the Case Review Team, 32 were found to be pregnancy related and 66 were not pregnancy related. Following the review of the 106 cases, the Case Review Team, which also serves as the Community Action Team, has recommended screening and education regarding postpartum depression and pharmacologic management of depression and other mental health issues during pregnancy and postpartum. In response to this recommendation, the NJDHSS has implemented an educational initiative for nurses, through the MCH Consortia.

c. Plan for the Coming Year

All local projects of New Jersey FIMR will follow the National FIMR guidelines for community FIMR in order to assure a process that will allow for coordination of New Jersey FIMR findings from a statewide perspective. Data and findings from local FIMR projects will continue to be submitted to the NJDHSS for inclusion in the statewide database. To improve the completion of maternal interviews in the coming year all projects will begin to use public health nurses to obtain the maternal interview.

The Perinatal Health Services will continue to coordinate the New Jersey Maternal Mortality Review process modeled after the National FIMR process.

State Performance Measure 3: *Percent of children with elevated blood lead levels*

a. Last Year's Accomplishments

The percent of children with elevated blood lead levels (State Performance Measure # 3) was chosen because children in New Jersey have a higher than average exposure to lead in their environment and a higher percentage of elevated blood lead than the national average. In

State FY 2003, 3.0% of children tested for lead poisoning in New Jersey had elevated (> 10 ug/dL) blood lead levels, which is 45% higher than the 2.2% rate in the 1999-2000 National Health and Nutrition Examination Study. Children with elevated blood lead levels are at increased risk for behavioral, physiological and learning problems. Increased childhood morbidity will result from undetected and untreated lead poisoning.

Significant progress was made toward SPM # 3 regarding childhood lead poisoning prevention. During State FY 2003, more than 183,000, blood lead tests were reported on 172,932 children. Of these, 90,112 were between six months and 29 months of age, the ages at which state rules require all children to be screened for lead poisoning. This is 40% of all children in that age group. Looking at all blood lead tests reported since 1999, it is estimated that 68.6% of children who were two-years old during SFY 2003, and 48.9% of one-year-olds, have had a least one blood lead test during their lifetime. Of the children tested, 3.0% had results > 10 ug/dl and < 1% had results > 20 ug/dl.

b. Current Activities

In March 2003, the DHSS published the FY 2002 Annual Report on Childhood Lead Poisoning in New Jersey for dissemination this data to local health departments and the public.

Working with the State's Immunization Program, the childhood lead poisoning prevention section of Child Health has developed a lead screening module for the Immunization Registry. Information from the lead data system will be downloaded into the Immunization Registry for easy retrieval by practitioners and the data from the Immunization Registry will be used to update the lead database as appropriate. The WIC Program has included within its database a module on immunizations, which also interfaces with the Immunization Registry. Additionally, Child Health staff have participated in a collaborative effort with Medicaid and its contracted managed care providers to increase the number of Medicaid-enrolled children screened for lead poisoning.

All children with elevated blood lead levels that require public health intervention are eligible for POrSCHe services (described earlier in this section) in target areas. Children in other areas of the State with elevated blood lead levels are served by their local health department as required by the State Sanitary Code (Chapter XIII).

DHSS is working in collaboration with the Department of Human Services, which is responsible for Medicaid and SCHIP in New Jersey, on sponsoring pilot projects to test the effectiveness of innovative methods to promote lead screening. These projects are in the cities of Camden and Irvington. The projects started in August 2002, and will be evaluated through December 2003.

In the highest risk city, Newark, the Child and Adolescent Health Program has partnered with the Newark City Department of Health and Human Services (DHHS) to establish the Newark Partnership for Lead Safe Children. The partnership has enlisted the support and participation of over 50 agencies/organizations in Newark. The partnership has been designed to empower the city and participating organizations to "take charge" of the lead problem in Newark. Newark DHHS has implemented a citywide lead poisoning prevention education initiative: "Lead Free is Best for Me". A small passenger van donated to the partnership by one of its members has been converted into "Leady Eddy" - a mobile lead poisoning prevention exhibit that travels to childcare centers and community sites to do education programs and lead screening.

c. Plan for the Coming Year

In January 2003, the DHSS provided new funds to establish regional childhood lead poisoning coalitions. Coalitions were formed in four regions, covering the whole state. The coalitions are comprised of the regional Maternal and Child Health consortia and local health departments,

with community partners. The activities of the regional coalitions were evaluated in February 2004. Revised regional plans for 2004-05 are to be submitted by June 2004.

Collaboration with the State's Immunization Program will continue to complete the lead screening module for the Immunization Registry /2004/ This has been completed. Collaborative efforts with Medicaid and its contracted managed care providers will continue in order to increase the number of Medicaid-enrolled children screened for lead poisoning. /2004/ Evaluation of the two pilot projects will be completed, and the pilot projects will be expanded to two additional communities.

State Performance Measure 4: *Percent of repeat pregnancies among adolescents 15-19 years of age*

a. Last Year's Accomplishments

The percentage of repeat pregnancies among adolescent mothers 15-19 years of age (State Performance Measure # 4) was chosen because teen parents are more likely to have another child within two years, often leading to increased hardship and economic dependency. This state performance measure will also impact on National Performance Measure # 8. The percentage of repeat pregnancies among adolescent mothers 15-19 has decreased from 8.2% in 1998 to 6.5% in 2002.

b. Current Activities

A demonstration parenting project, in Bridgeton, serving Cumberland County, continues to use home visiting to promote the physical and psychosocial health of low-income childbearing adolescents and their infants. To meet SPM # 4, the program supports their goals to complete high school or GED requirements, linking them to primary care providers, ensuring that both the teen and infant receive preventive and primary health care, and preventing unintended pregnancies. Since the inception of the programs, the rate of repeat pregnancies among participants has been 5%, there have been no substantiated child abuse or neglect cases, and over 95% of the children are age appropriately immunized. Two similar projects in Newark were discontinued in 2002 due to poor performance. One of these programs was picked up by the Department of Human Services as a Healthy Families project.

c. Plan for the Coming Year

The Advisory Council on Adolescent Pregnancy Prevention has developed a three-year strategic plan to guide the future work of the Council and focus on the implementation of teen pregnancy reduction initiatives in specific areas. The WorkFirst Teen Pregnancy Prevention Work Group led by the Department of Human Services plans to implement Youth-to-Youth programs, mentoring projects, and a Teen Pregnancy Resource Center. The statewide County Collaborative Coalitions and the regional forums will continue to bring together stakeholders and implement local adolescent pregnancy prevention activities and events for Teen Pregnancy Prevention Month.

State Performance Measure 5: *Percentage implementation of activities from the state plan to improve the nutritional and physical fitness of children and adolescents*

a. Last Year's Accomplishments

The DHSS is seeking the assistance of an advisory council to meet State Performance

Measure # 9, the development and implementation of a State plan to improve nutritional status and physical fitness of children and adolescents. The New Jersey Council on Physical Fitness and Sports was established under Public Law 1999, Chapter 265 to promote the health of the citizens of New Jersey by developing safe, healthful and enjoyable physical fitness and sports programs. The Council is directed to provide instruments of motivation and education, and to promote public awareness to ensure that all citizens of the State have the opportunity to pursue a healthful lifestyle. The Council consists of the Commissioner of Health and Senior Services or their designee and 15 public members appointed by the Governor, including one member each from the New Jersey Parks and Recreation Association, the Medical Society of New Jersey, the New Jersey State Interscholastic Athletics Association and the New Jersey Association of Health, Physical Education, Recreation and Dance. The NJ Council on Physical Fitness and Sports was legislated, appointments made by the Governor and the first meeting held in February 2001. The Council is extremely committed and has set a monthly meeting agenda in lieu of the required quarterly schedule. To date, the following is a sampling of accomplished activities:
- Developed a Council brochure, - Developed a Council exhibit to showcase Council and activities,
- Developed and produced a Council banner for display at conferences, - Co-sponsored the annual sports medicine conference with the Sports Medicine Committee of the Medical Society of New Jersey,
- Co-sponsored a series of four Be Fit Forums with the New Jersey Department of Education with Centers for Disease Control funding,
- Developed Council By-Laws,
- Developed a working draft of a 10-year strategic planning document, - Joined the membership of the National Association of State and Governors Councils and sent a representative to the annual meeting, and
- Solicited additional membership to the Council for "public members".
- The Annual Report of the Council was issued in January 2004.

The Osteoporosis Awareness and Education Act became law in 1997, and included a State appropriation. Primary prevention of osteoporosis must begin in childhood and continue through adolescence in order to build healthy bone mass. Activities during this grant year have focused on community-based initiatives to promote healthy eating behaviors and physical activity through the Community Partnerships for Healthy Adolescents initiative. Osteoporosis activities are coordinated with the Division of Senior Affairs, with consultation with the Interagency Council on Osteoporosis.

b. Current Activities

DHSS staff are collaborating with staff from the Departments of Education and Agriculture on activities to promote healthy nutrition and physical activity among school children. The focus of these activities for this year has been the planning for an annual New Jersey Healthy Schools Summit in May. Efforts are underway to collect student height and weight data from school nurses to estimate the prevalence of obesity among 6th graders in a sample of schools.

c. Plan for the Coming Year

In the coming year the New Jersey Council on Physical Fitness and Sports will continue to develop a strategic plan to promote the health of the citizens of New Jersey by developing safe, healthful and enjoyable physical fitness and sports programs. Funding will be provided to statewide and community-based organization, to conduct pilot projects to implement recommendations of the Council. DHSS will continue to collaborate with the Departments of Education and Agriculture on the New Jersey Healthy Schools Summit and other activities to promote healthy nutrition and physical activity among school children.

State Performance Measure 6: *Percent of children with birth defects who are appropriately reported to the NJ Birth Defects Registry*

a. Last Year's Accomplishments

State Performance Measure #6, the percentage of children with birth defects who are appropriately reported to the NJ Birth Defects Registry, was chosen to improve the quality of the Birth Defects Registry. The Birth Defects Registry has been an invaluable tool for birth defects surveillance, needs assessment, service planning and research. New Jersey has the oldest requirement in the nation for the reporting of children with birth defects. Beginning in 1928, New Jersey implemented reporting for children with orthopedic conditions. Since 1985, New Jersey has maintained a population-based Birth Defects Registry of children with all defects. This Registry supports the surveillance and service functions of CSHCN and children. Keeping the information as up-to-date and accurate as possible is critical for a population-based registry.
Recently, the SCHS Registry received a five-year cooperative agreement from CDC. Funding from this project will enable the staff to develop a web-based data reporting and tracking system.

b. Current Activities

Annual audits performed by the SCAEIS staff are necessary to identify children with birth defects that would otherwise not be entered into the Registry. The audits performed at every maternity hospital and facility with pediatric beds also provide an opportunity to provide reporting performance back to the individual facilities. While birth defects affect 3-5% of all newborns and are a leading cause of infant mortality, the cause of 67% of birth defects is unknown. Improving the infrastructure and quality of surveillance data is a prerequisite for developing better programs and advancing research toward prevention. Data from the most recent audit (2000 births) shows that hospitals reported 90% of newborns having birth defects.

c. Plan for the Coming Year

With the receipt of a new surveillance cooperative agreement from CDC, the registry is seeking to improve the electronic surveillance system and will develop an electronic linkage with the SCHS Case Management Units. This will enable the staff from the Registry to track the services received by children with birth defects.

State Performance Measure 7: *Percentage of completed Birth Defects Study interviews*

a. Last Year's Accomplishments

State Performance Measure #8, the percentage of completed Birth Defects Study interviews, is another example of SCAEIS building the capacity and infrastructure necessary to perform surveillance and research related to birth defects. New Jersey had the opportunity to apply for and was chosen as one of eight national Centers for Birth Defects Research and Prevention to collaborate with the CDC.

b. Current Activities

Beginning in August 1998, the case-control study was implemented. In total, 400 interviews are to be completed each year, 300 with cases and 100 with controls. During the total period of performance for this grant, 2216 interviews were completed. Interview response rates of 73% for cases and 66% for controls were among the highest of any of the eight Centers.

c. Plan for the Coming Year

The project period for this 5-year project has ended, and interviewing was suspended with births beginning in October 2002. One year funding was received to assist in improving the surveillance system for the SCHS Registry.

State Performance Measure 8: *Percentage of HIV exposed newborns receiving appropriate antiviral treatment to reduce the perinatal transmission of HIV*

a. Last Year's Accomplishments

SPM #8 was selected to focus efforts on reducing the perinatal transmission of HIV. Studies have demonstrated the dramatic reduction of perinatal transmission of HIV through the use of AZT. Accurately monitoring the identification and early management of pregnant women and at-risk infants should have a significant impact on reducing the perinatal transmission of HIV.

Early identification and AZT treatment of pregnant women identified as HIV infected appears to be reducing perinatal transmission to newborns. In looking at the number of reported cases of HIV/AIDS born in New Jersey, the number of infected cases dropped from 71 in 1993 to 2 in 2002. Each of New Jersey's seven Ryan White Title IV Family Centered HIV Care Network Centers has a dedicated perinatal care coordinator who is responsible for targeting outreach, counseling, testing and long-term follow-up of high risk adolescents and women of child bearing age. Pregnant women identified as HIV positive are referred to specialty clinics within the network. AZT treatment is provided during pregnancy, delivery and to newborns according to the CDC protocol. All newborns are referred and managed within the network. Co-located mother-child or family clinics have been established in each site to facilitate long term maintenance of mother and child in care. Preliminary data from the linking of mother/infant pairs indicates that 87% of perinatally exposed children born in New Jersey in 2000 had a history of receiving AZT prenatally, perinatally, and/or neonatally. Data from the more current 2002 Survey of Child Bearing Women (SCBW) indicated that 88.5% of the mothers/newborns received AZT at the time of labor/delivery. This is a marked increase from 13% in 1994, the first year SCBW specimens were tested for AZT.

In conjunction with the Division of HIV/AIDS Services, the Network established a Perinatal HIV Advisory Committee in 2000 to develop a statewide policy for rapid testing and short course therapy to reduce the risk of perinatal HIV transmission in women who present in labor with an unknown HIV serostatus. Committee representation included MCHC and SCAEIS staff, MCH consortia, OB and pediatric providers, Medicaid, and Ryan White Title IV Executive staff. In 2001 the Standard of Care for Women Who Present in Labor with Unknown HIV Serostatus was developed. The intent of the Standard of Care is to provide HIV counseling and voluntary rapid or expedited testing of mothers in labor or delivery, or newborns in nursery units, if there is no documentation of prior HIV testing. Maternal and/or newborn antiviral therapy will be offered if the test is reactive. A follow-up statewide survey indicated that 96% of respondents knew about the NJDHSS standard of care. Hospitals with policies for HIV counseling in labor increased by 88%. Hospitals with policies for rapid testing in labor increased by 77%, and now 95% of hospitals offer short course therapy to women with a preliminary positive rapid test.

b. Current Activities

With supplemental funding received in 2002 from the CDC, NJDHSS engaged the National Pediatric and Family HIV Resource Center to develop and implement a statewide Train-the-Trainer program. This program, directed to hospital OB nurse managers and educators, was designed to assist in staff training and policy development for the use of rapid testing and HIV counseling.

c. Plan for the Coming Year

The seven Ryan White Title IV Family Centered HIV Care Network Centers in New Jersey will continue in the coming year to target outreach, counseling, testing and long-term follow-up of high risk adolescents and women of child bearing age.

In FY 2003/2004, the Division of AIDS Prevention and Control will be conducting a statewide survey to determine the effectiveness of the training sessions on further reducing perinatal transmission.

State Performance Measure 9: *Percentage of communities receiving Community Partnership for Healthy Adolescent grants who have developed an adolescent health plan for their communities*

a. Last Year's Accomplishments

The NJDHSS is seeking the collaboration of local health departments, community-based organizations and health care providers to meet State Performance Measure # 9, the percentage of communities receiving Community Partnership for Healthy Adolescent grants who have developed an adolescent health plan for their communities. DHSS funds Community Partnerships for Healthy Adolescents in eight communities. The purpose of these Partnerships is to coordinate the work of local health departments, community-based organizations and health care providers in reducing risk-taking behaviors and promoting healthy behaviors among adolescents. Each Partnership's activities are based on a local needs assessment that identified the priority adolescent health issues in that community. An Adolescent Health Plan is then developed to address these issues. DHSS guidelines encourage the Partnerships to address sexual behaviors, injury prevention, and nutrition and physical activity.

The Community Partnerships have been funded since 1998. At that time, nine grantees were selected through a competitive process to develop Community Partnerships. In the Spring of 2003, the DHSS conducted a competitive renewal of this initiative through a Request for Applications (RFA) process. Through this process, it was determined that two of the existing Partnerships should continue, and that funding would be provided to six new communities. Each of the grantees has developed an Adolescent Health Plan for it's community, and have begun implementation activities in the 2003-2004 grant year.

b. Current Activities

DHSS currently funds Community Partnerships for Healthy Adolescents in eight communities. The purpose of these Partnerships is to coordinate the work of local health departments, community-based organizations and health care providers in reducing risk-taking behaviors and promoting healthy behaviors among adolescents. Each Partnership's activities are based on a local needs assessment that identified what the priority adolescent health issues were in that community. It then develops an Adolescent Health Plan to address these issues. DHSS guidelines encourage the Partnerships to address sexual behaviors, injury prevention, and nutrition and physical activity.

c. Plan for the Coming Year

In the coming year the Child and Adolescent Health Program will continue to strengthen coordination and linkages with school-based youth service programs, and improve intra/interagency communication so that limited resources can be effectively utilized to promote comprehensive services. Community Partnerships for Healthy Adolescents continues to

support the development of community-based, adolescent-focused partnerships that coordinate and implement activities and initiatives to address the adolescent issues specific to a community, as identified through a needs assessment process.

State Performance Measure 10: *Percentage implementation of activities from the state pediatric asthma plan*

a. Last Year's Accomplishments

Asthma has been identified as the most common chronic disease in children. In New Jersey in 2001, there were 5,492 hospitalizations and 8 deaths, among children 1 to 18 where asthma was the primary diagnosis. Hospitalization rates for asthma in the population under age 5 increased by nearly 12% between 1985 and 1999, while it decreased by 30% for children age 5-19 in the same period. Black non-Hispanic and Hispanic New Jersey residents are more likely to die or be hospitalized with asthma than white non-Hispanic residents. In the Special Child Health Services Registry, asthma is a condition for which voluntary registration is accepted, but less than 3,000 children are currently registered. A federal CDC grant, awarded in August 2000, is supporting the development of an asthma surveillance system for New Jersey. These funds enabled the hiring of a full-time asthma epidemiologist, in the MCH Epidemiology Program. Surveillance projects have included the completion of an annual Asthma Surveillance Report, an investigation of the impact of readmissions on pediatric asthma hospital admission rates, and an investigation of the association of aeroallergens and pediatric asthma hospitalizations. Strategic plans have been produced by the Interdepartmental Working Group on Asthma and the Pediatric Asthma Coalition of New Jersey. Based on these plans, the DHSS was able to obtain an increase in CDC funding to support asthma activities in New Jersey.

b. Current Activities

Staff from the Chronic Disease Program in SCA/EIS and the Child and Adolescent Health Program in MCCH have been participating in activities to coordinate and improve services for children with asthma (SPM #10), including issues of access. In 2002, the DHSS formed an Interdepartmental Working Group on Asthma. With the participation of staff from the Departments of Education, Human Services, and Environmental Protection, the working group prepared a strategic plan for the activities of New Jersey State Government in addressing asthma.

Staff have assisted the American Lung Association of New Jersey and the New Jersey Thoracic Society in creating a statewide Pediatric Asthma Coalition of New Jersey (PAC/NJ). PAC/NJ, with more than 100 participating organizations and individuals, has developed a strategic plan for addressing asthma in children in the state. Task Forces have been formed to address each of the five goals of the plan. These Task Forces have produced a number of significant products, including a model Asthma Action Plan, a Diagnostic Worksheet for physicians, and a teleconference training for school nurses and school classroom staff.

In 2003, the activities of the Coalition expanded to address asthma in adults as well as children. As a result of this, the Coalition's name was changed to the Pediatric/Adult Asthma Coalition of New Jersey. The Coalition developed a new strategic plan, the "Pathway to Asthma Control in New Jersey", incorporating objectives and activities addressing both children and adults.

c. Plan for the Coming Year

The Pediatric /Adult Asthma Coalition of New Jersey (PAC/NJ) has developed a Strategic Plan

to address asthma in New Jersey, and has formed six task forces to develop and implement activities to achieve the objectives of the Plan. DHHS staff will continue to participate on the Steering Committee of the Coalition, as well as on the School, Child Care, Education, and Health Insurance task forces.

The Interdepartmental Working Group on Asthma has also prepared a strategic plan to reduce pediatric asthma hospitalizations. A priority for the coming year is to complete development of a website for asthma information and education that will incorporate linkages to State and national resources.

FIGURE 4B, STATE PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) Percent of Black Preterm Births				
1. Healthy Mothers /Healthy Babies Coalitions	☐	☐	☐	☑
2. Healthy Start	☐	☐	☐	☑
3. Preconceptual health counseling/training	☐	☐	☐	☑
4. HealthStart	☐	☐	☐	☐
5. MCH Consortia outreach and education activities	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) Percentage of regional MCH Consortia implementing community-based Fetal and Infant Mortality Review Teams				
1. Implementing NFIMR in 7 MCHC Regions	☐	☐	☐	☑
2. Implementation of FIMR process uniformily across all projects	☐	☐	☐	☐
3. Reporting of data and local findings to NJDHSS for inclusion in statewide database	☐	☐	☐	☐
4.	☐	☐	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) Percent of children with elevated blood lead levels				
1. Registry and universal reporting	☐	☐	☐	☑
2. Newark Partnership for Lead Safe Children	☐	☐	☑	☐
3. Medicaid collaboration on pilot screening projects	☐	☐	☑	☐
4. /2005/ Regional Childhood Lead Poisoning Prevention Coalitions	☐	☐	☐	☐
5. /2005/Plan for Elimination of Childhood Lead Poisoning in New Jersey	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) Percent of repeat pregnancies among adolescents 15-19 years of age				
1. Comprehensive services for teens through Family Planning sites	☐	☑	☐	☐
2. Demonstration parenting project	☐	☐	☐	☐
3. Advisory Council on Adolescent Pregnancy Prevention completion of a three-year strategic plan	☐	☐	☐	☐
4.	☐	☐	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) Percentage implementation of activities from the state plan to improve the nutritional and physical fitness of children and adolescents				
1. Community Partnerships for Healthy Adolescents	☐	☐	☐	☑
2. KidStrong	☐	☐	☐	☑
3. NJ Council on Fitness and Sports	☐	☑	☐	☐
4.	☐	☐	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.				

	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) Percent of children with birth defects who are appropriately reported to the NJ Birth Defects Registry				
1. Annual Audits	☐	☐	☐	☑
2. Collaboration of 1 of 8 National Centers for Birth Defects Research and Prevention	☐	☐	☐	☑
3.	☐	☐	☐	☐
4.	☐	☐	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) Percentage of completed Birth Defects Study interviews				
1. Hypercoaguability study	☐	☐	☐	☑
2. Hypospadius and endocrine disruptors study	☐	☐	☐	☑
3. Collaboration with the N.J. Fetal Abnormality Program	☐	☐	☐	☑
4.	☐	☐	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) Percentage of HIV exposed newborns receiving appropriate antiviral treatment to reduce the perinatal transmission of HIV				
1. Ongoing outreach and education targeting pregnant women	☐	☐	☐	☑
2. Ongoing collaboration with Division of AIDS Prevention and Control	☐	☐	☐	☑
3. Perinatal HIV Advisory Committee involvementImproved outreach &				

early identification by New Jersey	☐	☑	☐	☐
4. Perinatal HIV Advisory Committee	☐	☐	☐	☑
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
9) Percentage of communities receiving Community Partnership for Healthy Adolescent grants who have developed an adolescent health plan for their communities				
1. Funding of Community Partnerships for Healthy Adolescents	☐	☐	☐	☑
2. Development of local needs assessment	☐	☐	☐	☑
3. Coordination of local health departments, community-based organizations and health care providers se	☐	☐	☐	☑
4. Development Adolescent Health Plans to address identified issues	☐	☐	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
10) Percentage implementation of activities from the state pediatric asthma plan				
1. /2005/Pediatric Adult Asthma Coalition of NJ	☐	☐	☐	☐
2. Asthma Surveillance	☐	☐	☐	☐
3. Special Child Health Services Case Management	☐	☐	☐	☐
4.	☐	☐	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

E. OTHER PROGRAM ACTIVITIES

State MCH program activities have considerable breadth. In order to adequately describe those activities which fall outside the parameters of priority needs and National and State performance measures outlined above, separate description may be necessary. Any activity not discussed within the priority needs and the performance measurement sections should be described here. These program activities often make significant contributions to the health and well-being of mothers and infants, children, and children with special health care needs within each State. Without these on-going program activities, the MCH population groups would not benefit from the full array of services available to them in some States. Each State has the opportunity to present these other activities in this section of the Application/Annual Report.

The Family Health Line is a programmatic component of the Center for Family Services, Inc. It coordinates the statewide hotline 1-800-328-3838. The Family Health Line provides free, confidential, 24 hours a day, seven days a week information and referral services in the State. It is based in the Division of Family Health Services, Perinatal Health Services Program. However, it covers the basic programs of the Division such as Maternal and Child Health, Family Planning, Cancer Education and Early Detection Services, Immunizations, Pediatrics, Women, Infants and Children (WIC), and others. The Family Health Line has a collaborative relationship with other social services agencies.

During the grant Year 2001-2002, the Family Health Line received and assisted a total of 9,923 calls, and made 9,714 referrals. In addition, the agency was highly selected to conduct the Governor's Immunization Campaign during the month of August, National Immunization Awareness Month, in New Jersey. The Perinatal Health Services Program cooperated with the Immunization Program, Division of Communicable Diseases, to assist the Family Health Line in referring callers to immunizations sites. The Governor's Immunization Campaign entailed an effective mass media component. As a result, 529 immunization referrals were made.

The Perinatal Health Services Program, Department of Health and Senior Services, is in charge of monitoring Family Health Line activities. It also coordinates quarterly staff training for the agency emphasizing current family health topics and issues. In Year 2002, the trainings covered WIC services, Fetal Alcohol Syndrome (FAS)/Perinatal Addiction, Oral Health and Prematurity/Folic Acid. The Program provides Family Health Line with current educational materials for consumer education on a regular basis.
/2005/ During the grant Year 2002-03, the Family Health Line received and assisted 10,986 calls, and made 12,842 referrals that indicate a record high. The Perinatal Health Services Program is in charge of monitoring the Family Health Line that is a component of the Center for Family Services, Inc. The program coordinates quarterly staff trainings for the agency with an emphasis on current family health issues. In Year 2003, the trainings covered Pediatric Health Systems, HealthyStart, Planned Parenthood Services and Prematurity/Folic Acid topics. The Perinatal Health Services Program provides the Family Health Line with consultation, technical assistance and educational material support.

During Year 2002, through a State act of legislation the Perinatal Health Services Program received funding to sponsor a Postpartum Depression (PPD) Initiative. Initially, a national search was conducted to select a consumer education brochure and a professional education module in order to meet the needs of the public and nurse practitioners. Accordingly, a self-diagnostic PPD brochure and a PPD nursing module were selected. The MCH Consortia were requested to disseminate 85,200 copies of the consumer education brochure that was accomplished. In addition, these agencies took charge of distributing 3,400 copies of the PPD nursing education module titled, "Postpartum Depression: Case Studies, Research and Nursing Care" by Cheryl T. Beck, DNSc., for nurse practitioners in Obstetrics/Gynecology (OB/GYN). The module included Continuing Education (CE) credits, and was provided free of charge.

F. TECHNICAL ASSISTANCE

The technical assistance needs of the State are reported on Form 15 and will likely be updated after submission of the MCH Blcok Grant Annual Report/Application.

V. BUDGET NARRATIVE

A. EXPENDITURES

Annual expenditures are summarized on Forms 2, 3, 4, and 5. Form 5, State Title V Programs Budget and Expenditures by Types of Service, parallels the pyramid shown in Figure 1, which organizes Maternal Child Health Services hierarchically from direct health care services through infrastructure building. There are no significant variations between fiscal year budgeted and expended funds or between fiscal year expended funds columns.

B. BUDGET

New Jersey has maintained and increased commitment of State funding support for maternal and child health activities. Since 1989, maintenance of effort has included State appropriations for children with special health care needs and support for population based outreach and education for pregnant women and their infants to name a few.

State appropriations support a number of maternal and child health programs. In the State fiscal year 2005 budget there have been a few proposed increases in State support. Most programs serving children and families and children with special health care needs and their families have remained level. There is continued commitment on the part of the State to support to the best of its ability services to the most vulnerable populations. Since the State budget will not be finalized until June 30, 2005, the following are the proposed funding levels for programs and services for FFY 2005 that reach maternal and child health populations in New Jersey:

Birth Defects Registry $ 525,000
Cleft lip and palate projects $ 610,000
Family Planning Services $ 4,300,000
Infant mortality reduction including a new project focused $ 2,205,822
on reduction of black infant mortality
Sudden Infant Death Syndrome $ 185,000
Childhood lead poisoning prevention $ 795,000
Hemophilia services $ 1,033,000
Catastrophic illness in children relief fund $ 1,606,877
Handicapped children's fund, which is used to support $ 2,059,000
subspecialty care and case management services
Fetal Alcohol Syndrome $ 570,000
MCH Services $ 3,403,000
Lead Testing Kits for pregnant women $2,000,000

Federally supported programs included in our federal state partnership for maternal and child health for FFY 2003 are as follows:

From the Centers for Disease Control and Prevention:
Childhood Lead Poisoning Prevention $ 1,105,400
Preventive Health and Health Services Block Grant $ 737,598
Asthma Surveillance $ 200,000
Early Hearing Detection and Intervention $ 130,000
PRAMS $ 149,548

From the Maternal and Child Health Bureau
State System Development Initiative $ 132,836
Abstinence Education $ 843,000
Mortality Review Coordination $ 72,000
Universal Newborn Hearing Screening $ 220,000

From Other Federal Sources

Ryan White Pediatric AIDS $ 2,072,878
Family Planning $ 3,121,766
Perinatal Addictions $ 385,000
Primary Care Cooperative Agreement $ 215,737
Social Service Block Grant $ 1,922,000

All of the funding sources are considered in the programmatic narrative portion of this application. There have been few variations in the allocation and expenditure of the federal/state partnership funds for maternal and child health over the last few years. State appropriations have included cost of living increases that are passed on to the service providers. New Jersey has undertaken several new or expanded initiatives over the past few years, which may in some cases, resulted in slight variations in allocations or expenditures. The annual Title V budget is summarized below. The following federal and state programs are targeted to meet performance measures and goals in the areas of maternal and child health for Year 2005 proposed or projected (the funding sources listed is not all inclusive):

Perinatal Health Services - State:
Fetal Alcohol Syndrome $ 450,000
Healthy Mothers / Healthy Babies $ 1,856,159
Black Infant Mortality Reduction $ 500,000
SIDS Resource and Counseling $ 185,000

Perinatal Health Services -- Federal:
Perinatal Addictions -- Substance Abuse Block $ 385,000
Healthy Start -- Irvington/Newark $ 500,000

Child and Adolescent Health - State:
Childhood lead poisoning prevention activities $ 795,000
Leading Testing Kits $ 2,000,000
Reproductive Health Family Planning $ 4,300,000

Child and Adolescent Health -- Federal:
CDC Childhood Lead Poisoning Prevention $ 1,105,400
State System Development Initiative $ 737,598
Preventive Health and Health Services Block Grant $ 692,603
Abstinence Education $ 843,000

Federal-State MCH Block Grant Partnership Budgeted FY 2003
a. Pregnant Women $ 4,901,766
b. Infants < 1 year old $ 4,636,945
c. Children 1 to 22 years old $ 9,891,684
d. CSHCN $10,953,277
f. Administration $ 1,011,000

SUB-TOTAL $31,394,672

II. Other Federal MCH Related Funds

a. WIC
b. SPRANS
c. EMSC
d. AIDS $ 2,072,878
e. Healthy Start $ 500,000
f. CISS $ 0
g. CDC $ 3,099,467
h. Education $ 0
i. Abstinence Education $ 843,000

j. SSDI $ 132,836
k. Social Security BG $ 1,922,000
l. Family Planning $ 3,121,766
m. Early Intervention $ 10,193,673
n. all others $ 971,013

SUB-TOTAL $ 22,856,633

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting Documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.